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IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

Volume 133, Number 1

January, 1968



In diarrhea of acute gastroenteritis...



LOMOTIL® Tablets
Liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

• Lowers Motility • Allays Diarrhea • Limits Disability

No matter how quickly diarrhea may subside, it seldom subsides quickly enough for the patient.

The lack of laboratory methods for promptly identifying the causative organism increases the importance of symptomatic and supportive therapy.

Lomotil is a simple, highly acceptable agent, free of the major disadvantages of the opiates, for prolonging intestinal transit time and limiting the duration of diarrhea. With Lomotil to control intestinal hypermotility and diarrhea, patients are more comfortable and frequently are able to resume normal activities sooner.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia; continuous observation is recommended. Lomotil

should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial *daily dosages*, given in divided doses until diarrhea is controlled, are:

Children:

3-6 mo. . . ½ tsp. t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . 1 tsp. 5 times daily (10 mg.)

Adults: . . 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE Research in the Service of Medicine

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BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 1

January, 1968

New Programs For Over-65 In The Making

Because Medicare benefits do not apply uniformly to all persons over-65 after January 1, 1968, Blue Shield and Blue Cross will offer surgical-medical coverage to those not covered by Medicare Part A and/or Part B.

For present Blue Shield-Blue Cross group subscribers who do not qualify for Medicare, continuation of the basic benefits of the group will be permitted.

For all others, members or non-members of the Plans, the H-300 Blue Shield Certificate and the Series-65 Blue Cross Certificate will be made available. These basic benefit programs are not new Certificates, but will again be offered (suspended since July 1, 1966) to persons over age 65, and rated separately.

A new Series-65 Medicare Supplementary Program is being prepared for coordination with the government program changes recently. As you know, the changes in the Medicare benefits are scheduled for April 1 and we will tell you more about their effect prior to that time.

For non-group Medicare beneficiaries, Blue Shield and Blue Cross presently offer a combined \$10,000 supplemental Major Medical plan. After a deductible of \$100, the Plans pay 80% of all eligible expenses not paid by either Part A or Part B of Medicare.

It is our thinking that present subscribers holding Series-65 Major Medical Certificates will be offered the opportunity to switch to the proposed program. Cost will be slightly higher, but we will be providing greater coverage and every hospitalized member will benefit. Besides providing more dollars in coverage, the Plans can promise faster, more efficient claim service since hospitals and doctors may bill the Plans directly and be paid directly as in the case of our under-65 basic certificate holders.

Formal announcement of these programs will be made as soon as possible. Availability to the public will come once necessary approvals have been obtained.

Annual Dinner For Medical Assistants

For more than ten years the Blue Shield Plan of Illinois Medical Service has held dinner meetings for Medical Assistants in the area we serve to help keep them abreast of changes in Blue Shield procedures, benefit structures, and methods.

Starting in April meetings will be held for Medical Assistants in the central and southern counties of Illinois. All Medical Assistants will be invited. Following dinner, executives of the Plan will discuss matters relating to Blue Shield operations and will answer questions relating to Blue Shield activities. Medical Assistants will be notified as soon as the meetings are scheduled. They will be held in central locations.

Twenty meetings were recently concluded in the northern counties which were attended by over 2500 Medical Assistants. The Assistants informed us that the meetings were instructive and helpful to them in carrying out their responsibilities for their physician-employers.

Medical Assistants and physicians who have questions regarding the Physician's Service Report form or other Blue Shield forms may contact Mrs. Loretta O'Donnell, 425 North Michigan Avenue, Chicago, Illinois 60611.

Fill Out Report Even If Patient Has Paid

It is necessary to answer the question on the *Physician's Service Report*, "Has your patient paid your bill?" so we can reimburse the member if the bill has been paid.

The physician is also asked to indicate the amount of his fee. We use this information for statistical purposes and to guide us in revising our schedules of allowances. Such information is required as a condition of payment under the terms and conditions of all Blue Shield Certificates and is particularly important to know in order to make payments under our new "usual and customary" certificates.

(This is not an advertisement)

ASK BLUE SHIELD

Q Why do surgical payments for the same procedure vary for different patients?

A The indemnity payments vary according to the type of certificate the member has and the price that is paid for it.

Q Are diagnostic x-rays, as well as gallbladder series, paid for when done in the doctor's office?

A These benefits are not covered in the doctor's office unless diagnostic benefits are part of the basic Blue Shield certificate or are included as a rider.

Q Why are repeat procedures performed in the outpatient department of the hospital or in the doctor's office disapproved?

A Most Blue Shield certificates cover one procedure in a 90 day period.

Q Why are letters sent to doctors asking the date of onset of a condition?

A Some certificates have a 270 day waiting period for named or pre-existing conditions in addition to the 270 day waiting period for obstetrical benefits.

Q Does the member know the amount of benefits paid to the physician?

A Yes. A voucher copy of the check is sent to the member.

● ● ● ABOUT MEDICARE

HOUSE, SENATE PASS SOCIAL SECURITY—MEDICARE BILL incorporating many changes in the current Medicare program.

A key provision of the bill permits Medicare patients to be reimbursed on the basis of "itemized" and unreceipted bills.

Under present law, payment may be made only by assignment to the physician or to the patient upon presentation of a receipted bill. The amendment permits payment either to the patient on the basis of the "itemized" bill (which could be either receipted or unpaid) or to the physician accepting an assignment.

Among other changes, the bill has dropped initial physician certification for hospitalization; has transferred out-patient hospital diagnostic services to Part B of Medicare; and will fully reimburse inpatient pathological and radiological services.

We will keep you informed of Blue Shield responsibility as Part B carrier in the counties of Cook, Lake, Will, Kane, and DuPage, as soon as our instructions are complete. In the meantime, additional information may be obtained by writing to: Blue Cross-Blue Shield, Government Contracts Division, 300 North State Street, Chicago, Illinois 60690.

Complete Information Speeds Payment

When the information supplied by the physician is incomplete, it is necessary for us to contact him before we can make payment.

Details in connection with description of the services provided or procedures performed help us in making prompt payments.

It is also important for us to know the subscriber's name, which appears on the identification card, and the name of the patient. The certificate number is essential for positive identification.

It is also important to include on Blue Shield's *Physician's Service Report* the patient's age as our electronic processing equipment will reject a report when a patient's correct age is not indicated.

Reporting Procedures

Whenever a Blue Shield member receives care which is covered by Blue Shield benefits, the physician should fill out a *Physician's Service Report Form* as soon as possible and return it to Blue Shield headquarters.

Blue Shield has designed the *Physician's Service Report Form* not only to conserve the time and effort of the physician but also to request only information essential to evaluate the claim. To expedite processing, physicians are requested to answer all questions.


Most *Physician's Service Reports* are processed electronically and it is important that they are accurate and complete. We want to make payments promptly and strive to improve this service wherever we can.

We suggest that physicians retain duplicate copies of each report for their files or that they record each report on the record sheet included in each pad of Blue Shield *Physician's Service Report forms*.

Our Government Contracts Division

reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during November for over 49,000 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding \$2,450,000. For the year 1967 through November, payments have been made on over 454,000 cases for an amount exceeding \$26,000,000.

The number of cases processed in November under Part A exceeded 65,000 with payments to providers amounting to more than \$16,000,000. For the year 1967 through November over 549,211 cases have been processed and payments to providers have exceeded \$166,600,000.



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OBEDRIN®-LA
OBEDRIN MENU PLAN**

A slim figure is the glamour goal of most women. In your practice, though, you undoubtedly see many women and men who should lose weight for fundamental health reasons. Your professional guidance plus Obedrin-LA and the Obedrin Menu Plan can help keep patients on your program longer. One tablet taken daily trickle-releases medication in a balanced ratio to curb appetite and sustain mood. Write for a free supply of the Obedrin 1000 Calorie Menu Plan.

DOSAGE: OBEDRIN-LA—1 daily, usually at 10 a.m. OBEDRIN Tablets and Capsules—1 tablet or capsule at 10 a.m. and 3 p.m. If necessary to suppress late evening hunger, another tablet or capsule may be taken at 8 p.m. OBEDRIN tablets are grooved so a half tablet can be taken if it is found sufficient for appetite control.

SUPPLY: OBEDRIN-LA—Tablets, two-layer in bottles of 50 and 250. OBEDRIN—Tablets in bottles of 100, 500 and 1000; Capsules in bottles of 100 and 1000.

Caution: Federal law prohibits dispensing without prescription.

CAUTION: Should not be given concurrently with monoamine oxidase inhibitors. It should be used with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

SIDE EFFECTS: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage.

**"Trickle-Release" Tablets
Obedrin®-LA**
Each tablet contains: Methamphetamine HCl, 12.5 mg.; Pentobarbital, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg.

**Obedrin®
Tablets and Capsules**
Each tablet or capsule contains: Methamphetamine HCl, 5 mg.; Pentobarbital, 20 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 100 mg.; Thiamine Mononitrate 0.5 mg.; Riboflavin, 1 mg.; Niacin, 5 mg.

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The president's page



Newton DuPuy, M.D.

Abraham Lincoln had much to say about unity which would be useful to recall today when medicine is under seige.

The difficulty, of course, is that individualism is at once our greatest strength and our greatest weakness. Doctors need to be individualists, but they also need to be members of a mighty profession that is not only dedicated to protecting the individual rights of physicians as well as promoting and preserving the public health.

We all know a few colleagues who are careless about keeping up with the advance of medical knowledge, but for each one of these there are at least a dozen more who fail to keep up with the world in which medicine must function.

Those who pride themselves on being above what they choose to call the "political" aspects of medicine, are short-sighted, unimaginative, and are trying to exist in an unreal world.

Admittedly, it is no small task to keep abreast of everything we should know, but being capable of it may have something to do with the reason why many are called but few are chosen to be physicians.

To help doctors see both the forest and the trees, the medical profession has devised a federation of local, state and national societies that serve as the eyes, ears and voice of the physician in the United States.

The physician's principal contact, of course, is with his own county society, and the physician who neglects its meetings and its activities, sacrifices his right to be heard in the larger voice. He has already lost contact with the world as it affects him and his practice, and he has no right to complain that the AMA or the Illinois State Medical Society does not speak for him.

To make the system work, it is important that every doctor maintain close contact at the county level. It is his responsibility to see that this organization is a living, breathing arm of organized medicine. He should be sure that the officers he elects are conscientious and dedicated to the art of communication upon which his welfare depends.

Too often we hear criticism that the state and national organizations are autocratic, too far removed from the grass roots. Perhaps it is time for a little introspection on the part of the grass roots. For example, in Illinois, we have found that only 40 percent of our county organizations respond with any degree of promptness to communications from state headquarters. Some never get around to it.

The immediate fault, of course, is that the county society secretary is a busy practitioner with many patients and little or

(Continued on page 88)

HEW, Hospitals Agree on New Payment Plan

The Social Security Administration, in cooperation with the American Hospital Association, has developed a new method of paying for hospital services under medicare, according to John W. Gardner, Secretary of Health, Education, and Welfare.

Beginning Jan. 1, 1968, Gardner said, hospitals will be able to count on receiving an agreed-upon uniform medicare payment each week. This new method, which may become a prototype for other hospital insurance plans, will:

- help hospitals improve their financial planning and day-to-day management.
- substantially reduce detailed paperwork.

Detailed statements of services and charges will no longer be required in advance of medicare payment, the Secretary noted. Instead, a hospital's weekly payment will be based on an estimate of the cost of the services it expects to furnish to medicare beneficiaries in the course of a year. It will receive that amount weekly in 52 installments.

Adjustments in the amount of the payment can be made at any time to reflect current cost experience. Final settlement and audit will take place once a year.

The idea for this new medicare payment plan, Gardner noted, was first suggested by Thomas M. Tierney, the Social Security Administration's new medicare director, who until last April was President of Colorado's Blue Cross Plan.

"The American Hospital Association is to be commended," Secretary Gardner said, "for its demonstration of responsible professional leadership and interest in the effi-

cient administration of a program that is contributing so much to the well-being of our older citizens."

There were over 6 million admissions to hospitals under medicare during the first 15 months of its operation, he said, involving about 5 million people. Over \$3 billion has been paid to hospitals for these services.

Physicians have arranged home health care for about 300,000 people, and since Jan. 1, about 300,000 people have been admitted to extended care facilities.

About a billion dollars has been paid under the voluntary program which covers primarily physicians' bills. The somewhat over 20 million bills for physicians' services, covering a great variety of services, have averaged \$38 each. The surgical bills, as would be expected, were considerably more and taken alone averaged about \$132 per bill.

There are about 6,900 hospitals participating in the program, about 4,200 extended care facilities, 1,900 home health agencies, and 2,400 independent laboratories. Seventeen and three quarter million people over 65, or 93 percent of all the older people in the country, have enrolled in the voluntary medical insurance part of medicare.

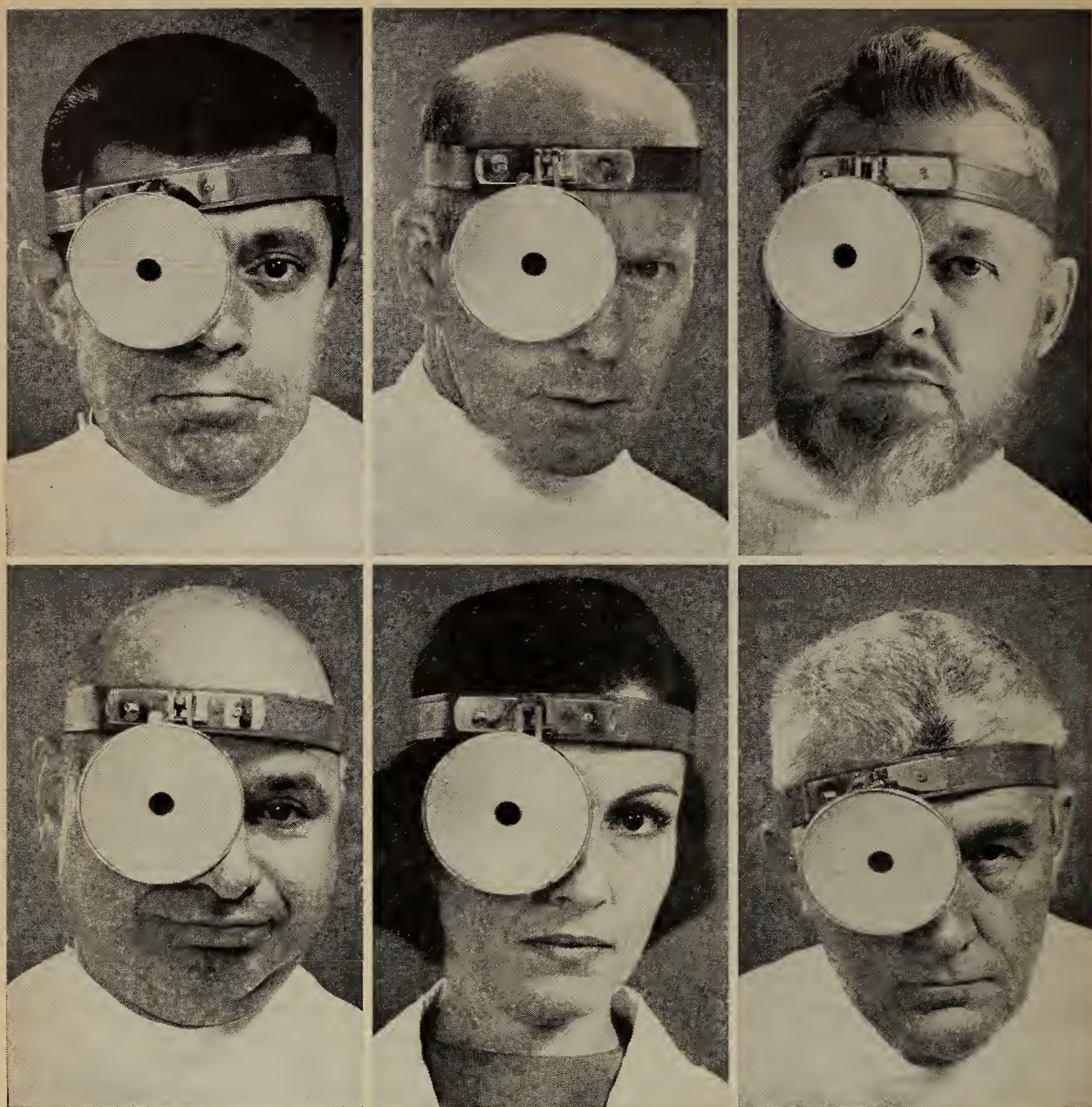
Processing time for the payment of claims has been greatly reduced in recent months, Secretary Gardner stated. The average time nationally required to process physicians' bills is now about two weeks. This is a reduction, he said, from an average processing time of about five weeks at the first of the year and about two and one-half weeks in June.

Medical School Applicants and Enrollments, 1966-67

A total of 18,250 persons applied for admission to the 1966-67 first year class in U.S. medical schools, according to the Association of American Medical Colleges. This is the second year in a row in which there has been a decrease in the number of applicants following a high of 19,168 in 1964-65. It is anticipated that the number of medical school applicants to the 1967-68 class will increase somewhat or remain approximately the same. A recent trend toward heightened application ac-

tivity continued in 1966-67 with an average of 4.8 applications per applicant. The resulting total of 87,627 applications represents a new high. One-half the total medical school applicants were accepted for the 1966-67 first-year class, including 438 who did not matriculate. A multistage selection process ensures the issuance of sufficient acceptances to fill all available spaces. The first year medical school enrollment was 8,991.

(Continued on page 71)



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegra-

tion, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.





"Yes, Doctor, the pain is gone."

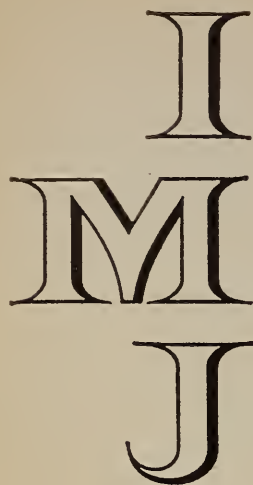
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Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

- Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.



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Medical Education In Early Illinois

By EMMET F. PEARSON, M.D., AND ROSS J. SCHLICH, M.D./SPRINGFIELD

Illinois will celebrate its 150th year of Statehood in 1968. On Dec. 3, 1818, President James Monroe signed the Act of Congress by which the territory of Illinois became the 21st State in the Union.

To commemorate this sesquicentennial event, the Committee on Archives will present a series of articles recounting the history and progress of medicine in Illinois. Interested authors are invited to submit appropriate articles for future issues.

This article has been prepared by Emmet F. Pearson, M.D., Chairman of the Archives Committee and Ross F. Schlich, M.D. of Springfield. It recounts the drama and growth of medical education in early Illinois.

As we contemplate the medical education requirements of the 21st century and the Illinois Bicentennial it is well to reflect on the early efforts to train Illinoisians to provide the health needs of their times. Some pioneer Illinois doctors were men of vision, ideals and wisdom and established a favorable image for good medical training and practice. One hundred and fifty years ago there were no medical schools in Illinois, but a quarter century later there were new adventures in education of native doctors in several widely separated towns.

In 1818 most of the population of Illinois lived south of the confluence of the Illinois and Mississippi rivers. After the Indian Treaty of Edwardsville in 1819, the Black Hawk War of 1832 and the Treaty of Chicago in 1833, rapid immigration and expansion into the northern counties, recently occupied by Indians, occurred and a supply of doctors was necessary to follow the immigration to new and burgeoning

towns, including Chicago. Available medical talents during this epoch encompassed extremes of training and ability.

Priests and Military Surgeons

The earlier French population along the Illinois side of the Mississippi river, at Kaskaskia, Prairie du Rocher and Cahokia, depended upon the priests for medical knowledge and nothing is recorded concerning medical education in the settlements. The military operation in Illinois of the Spanish, French, British and American forces were usually accompanied by military surgeons, but they did not remain long in any place and apparently did no teaching.

The earliest English settlements at Alton and around the Wabash river contained many intellectuals and a few doctors but none appeared to do any formal medical teaching.

Most medical education in early Illinois was done by preceptorship or by "reading" medicine under the tutelage of a "respectable" practitioner. For anatomical dissection the student found a recently buried body, preserved it and hid it from the prejudiced public. A vivid description of this type medical education, in Illinois, is given by the writer McKinley Kantor in the historical novel "Spirit Lake." In this account (Kantor's historical research is usually considered quite reliable), young Dr. Issac Harriott was apprenticed to a doctor in Pekin and later to another in Atlanta, Ill. He thought of taking some lectures at the new medical schools at Jacksonville or St. Charles, but didn't take the time. Like

most adventuresome doctors of his time Dr. Harriott moved on with immigration to other states. He immigrated to Minnesota and Iowa.

Quacks, Cultists and Medicine Men

Many of the doctors that moved into the new states of the west received their medical education or apprenticeship in Illinois.

There were many quacks, uneducated charlatans, herb doctors and other cultists, including Indian medicine men, who degraded and often gave a bad image to medical practice of the early times.

Most well educated doctors in Illinois prior to the 1840's came into the state from Kentucky, Ohio and the East. St. Louis Medical College, founded in 1840, supplied a few recruits for Illinois. Most of these honorable, humanitarian, dedicated practitioners were generally held in highest esteem. Some saw the need for medical education in the new state and organized the first medical schools.

The first medical schools in Illinois were predominantly country schools, contrary to those in the East where medical education was concentrated in large cities. The Franklin Medical School of St. Charles, founded in 1842, is generally considered the first school organized toward granting a medical degree; although medical teachers in Quincy, Shawneetown, and Galena taught groups and hoped to found medical schools. The Illinois College Medical School of Jacksonville and Rush Medical School of Chicago both began in 1843. Rush lasted a hundred years, the Illinois College Medical School closed in 1848 and the St. Charles College last only until 1847. Rock Island Medical School, founded in 1848, moved to Davenport the next year and merged into the State University of Iowa.

Fairfield Medical School

Interestingly enough, the key physicians of three of the four schools originated from an exemplary country school in the East, Fairfield Medical School of Fairfield, N.Y. They were Daniel Brainard and Nathan S. Davis of Rush, George W. Richards of St. Charles and David Prince of Jacksonville.

Of these four early medical schools, Illinois College Medical School had the distinction of being the only one associated with a college. Illinois College had been



established in 1829 by a group of Yale missionaries and the first president was Rev. Edwin Beecher, brother of the renowned Henry Ward Beecher. The Jacksonville Female College, founded in 1830, had already set the precedent of being the first women's college in the West. Both colleges grew steadily in their first decade and by then resolved to add the departments of law, medicine and theology to the college.

The departments of instruction listed in the minutes of the board meeting of the Illinois Medical College, June, 1843, were: Anatomy and Surgery; Chemistry and Materia Medica; Theory and Practice of Medicine; Obstetrics and Diseases of Women and Children. The new medical school, while attempting to set uniform standards for admission and high standards for the degree in medicine, was obliged to leave loopholes for students of poorly educated pioneer families or face the prospect of a vanishing enrollment.

Doctors as Gentlemen and Scholars

There were the days when the best doctors were gentlemen and scholars, just as they always have been and are today—but with a different flavor. In 1838, after several years of practice, Dr. Samuel Adams accepted the chair of natural philosophy, chemistry, and natural history at Illinois College, Jacksonville. He was later professor of materia medica and therapeutics in the medical department. During his teaching years he instructed in almost every branch in the curricula, including French and German. He was a graduate of Bowdoin in the departments of both literature



Beecher Hall (Constructed 1829; renovated 1950) is the first college building erected in the State of Illinois. During the College's history, the building housed the first medical school in Illinois (1843-1848). During this period, a mob gathered about the medical school looking for the Professor of Anatomy and his helpers, who were accused of exhuming the body of Governor Duncan for anatomical study. Such distrust and lack of sympathy for medical education was an obstacle the Illinois College of Medicine could not overcome.

and medicine and came to Jacksonville from Maine at the age of 32.

Dr. David Prince was a native of Connecticut and specially trained in teaching Anatomy, a rare find in those days. After graduating from Ohio Medical College, in Cincinnati, he practiced with a famous surgeon of the day, Dr. Reuben D. Mussey. At age 27 he joined the faculty at Illinois Medical College as Professor of Anatomy where he remained two years, 1843-1845. When Jacksonville began to lag as a medical teaching center he became Professor of Surgery in the St. Louis Medical College as well as a practitioner. He preferred to practice surgery in Jacksonville and returned there in 1852. He became a brigade surgeon during the Civil War. In 1881 he was honored as a delegate to the International Medical Conference in London, and again in 1884 as a delegate to the Copenhagen Conference. In Jacksonville he established a sanitarium for the care of chronic diseases and surgical patients and continued in this work until his death in 1889.

Distrust of Medical Schools

Precisely why the medical college, at Jacksonville, ceased to exist after five years is not clear. A number of factors were influential. The Illinois Medical College was better equipped than Rush from all accounts, but Chicago was a more aggressive town and therefore Rush gained greater support from influential people. The climate of distrust of early medical schools was another factor that plagued not only the College at Jacksonville but also the early medical colleges at Chicago and St. Charles. The problem of obtaining subjects for dissection was difficult to surmount. Once a mob gathered about the Medical College at Jacksonville looking for the Professor of Anatomy and his helpers, who were accused of exhuming the body of Governor Duncan for anatomical study. Such distrust and lack of sympathy for medical education was an obstacle the Illinois College of Medicine could not overcome.

The influence of the early medical educators in Jacksonville, however, went be-

yond a medical school. A building for the education of the deaf and dumb was complete in 1846 and 13 pupils were admitted. Drs. David Prince, Samuel Adams and Edward Mead, who furnished the principal leadership for the Medical College, were key figures in the organizational work to establish an institution for the treatment of the insane. This was accomplished in 1854 after several years delay because Illinois was in financial trouble at the time. Prior to this, in 1850, a state institution for the blind was opened with 23 pupils under the superintendence of Dr. Joshua Rhoads. The professors of Illinois Medical College at Jacksonville were energetic men of broad vision, setting medical milestones in rough country during the time when anesthesia was an unfamiliar word and had just been discovered.

Lincoln and The Doctors

Medical education in Illinois was profoundly influenced by the eminent professor Dr. Daniel Drake, of Cincinnati, who came to Illinois on an extended study trip in 1844. His image was an inspiration to all fledging doctors of the state. Dr. Drake met Abraham Lincoln and later Mr. Lincoln wrote to Dr. Drake in Cincinnati telling of his many complaints and asking for remedies. The good doctor kindly replied that if the patient would come to Cincinnati he would be glad to examine him and see what he could do. Incidentally, Mr. Lin-

coln was very closely associated with many doctors of strong character who must have had profound influence on the complicated character of the man.

Since 1848 most formal medical education in Illinois has been carried on in Chicago. With five great medical schools and many magnificent medical facilities, Chicago has become one of the great medical centers of the world. It has been said that about one-fourth of all medical practitioners in the nation received a part of their medical training in Chicago.

New Visions in Medical Education

At a recent conference on medical education for the future, held in Springfield, many leading educators and advanced thinking guests spoke of new visions in medical and health education to supply the needs and demands of the future society. Radical departures from orthodox contemporary medical education were discussed. Education of the entire medical team with the many paramedical personnel as a unit to cope with all aspects of community life is one idealistic approach. The possibility of establishment of a new composite medical education center in downstate Illinois is being discussed in educational circles, medical groups, in legislative halls and by the interested public. Great vision and wisdom is needed now as it was in Illinois 150 years ago.

SHADOWS OF COMING EVENTS

The problem in the U.S.A. is that no longer do people have "their doctor" whom they can afford, and to whom they can go for help, whether the reason is serious, trivial, or merely to talk something over. It is often difficult to know whom else to approach at any given time, especially when frightened and confused, and if a doctor is unknown. They thus tend to use the out-patient department of the large hospitals more and more as their solution and substitute for the general practitioner's office. There they will be attended, and very well too, by the interns and residents on duty, but it is impossible for any continuity of care to be maintained with any one doctor — surely the key to a good general practice. The idea of the general practitioner knowing the family, its problems, and its peculiarities over many years, and acting the key role in care at home and as co-ordinator when specialist advice is necessary, is perhaps considered old-fashioned by some, but I still feel it to be important.

In my experience there are other disturbing consequences of this trend. Firstly, there has in many instances been a loss of doctor-patient loyalty. Patients change their doctor from month to month, illness to illness, and even during an illness in a way one might change shops if unsatisfied with service. The fault must lie on both sides, but for continuity of care it is disastrous and could be dangerous.

— Brit. Med. J. 1: 507, 1965.

Anesthetic Complications in the Delivery Room

By BRADLEY E. SMITH, M.D. / MIAMI, FLORIDA

Obstetrical anesthesia still ranks third or fourth as a cause of maternal mortality and contributes about 20 percent of all preventable direct obstetric deaths¹. Most of this mortality is preventable and is the direct result of lack of planning, both in the prevention of accidents in anesthesia, and in therapy of the emergencies which do arise. In addition, anesthetic accidents are an important cause of infant mortality and morbidity. Several of the more frequent of these emergencies will be described here, along with methods of prevention, and treatment.

Aspiration of Vomitus

Aspiration of vomitus remains the major cause of obstetrical anesthesia mortality contributing up to 60 percent of the maternal deaths due to anesthesia². About one in 10 obstetric patients has been estimated to vomit under general anesthesia, and nearly a third of these go unnoticed³. The classic description by Mendelson⁴ of cyanosis, wheezing, dyspnea, and tachycardia usually accompanied by frothy pulmonary edema is nearly pathognomonic.

Aspiration can best be avoided by rigid refusal to submit a woman who is suspect of having eaten recently to a general anesthesia. Regional anesthesia such as spinal, caudal, or pudendal block is preferable, and they may be used along with subanesthetic (therefore nondepressing) inhalational analgesia.

When these methods are not applicable, endotracheal intubation is essential, preferably with the aid of topical anesthesia before induction of general anesthesia. However, when circumstances will not permit this, rapid intubation with the aid of succinylcholine is next best. The endotracheal tube should then be left in place until the patient is reactive and coughing on the tube.

Treatment for the patient who has aspirated is a true medical emergency. Mortality from massive aspiration of vomitus can be as high as fifty percent. Aspiration of vomitus calls for immediate endotracheal intubation and suctioning. Care should be taken to maintain oxygenation during this period. Immediately, 200 mg. of hydrocortisone and one million units of aqueous penicillin should be given intravenously (if no allergy exists). If desired, other antibiotics may be substituted or added but there must be high and prompt blood levels established. (High doses of corticoids and the antibiotics should then be continued for the first few days)⁵.

Intratracheal saline or sodium bicarbonate washes are contraindicated since they have been shown to increase the hypoxia, wash out "surfactant" from the lungs, and actually to spread the acid farther through the lungs.

Bronchoscopy should be attempted to

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clear out large chunks of food as soon as adequate oxygenation is established. If, however, there is good evidence there are no actual food particles, bronchoscopy should be deferred, since it has its own dangers under these emergency conditions.

These patients usually develop a severe, frothy, pulmonary edema due to a "burn" like reaction of the respiratory tract. This foam may prohibit proper respiratory exchange and, if so, three milliliters of absolute alcohol in seven milliliters of distilled water should be breathed as a nebulized aerosol.

In severe cases atelectasis, cyanosis, and poor lung expansion is very likely to develop. In these severe cases intermittent positive pressure breathing through an endotracheal tube, or even a tracheostomy, from a machine such as a Bennett or a Bird respirator is needed. This will promote re-expansion of atelectatic areas and suppress pulmonary edema formation.

Corticoids, antibiotics, and vigorous efforts to avoid or treat atelectases are the essentials for saving these patients.

Hypotension and Circulatory Failure

Hypotension and circulatory failure has been estimated to account for 34 percent of maternal deaths due to anesthesia² and in addition, can be significant hazard to the fetal passenger⁶. The most frequent cause of hypotension is sympathetic blockade from spinal anesthesia, which induces hypotension below 100 mmHg. systolic in about 54 percent of cesarean sections under spinal and in 18 percent of "saddle blocks" for vaginal delivery⁶.

Fetal electrocardiography⁶ and clinical studies⁷ have shown that 100 mmHg. is frequently the minimum pressure necessary for perfusion and levels below this should not be allowed to persist. However, vasopressors similar to methoxamine and phenylephrine which act primarily as peripheral constrictors markedly depress uterine blood flow⁸ and should never be used in obstetrics. However, the use of ephedrine in a very large clinical study was shown to protect the fetus against the effects of hypotension, and was statistically significantly more favorable for the fetus than methoxamine⁷.

The *inferior vena caval compression syndrome* accounts for about one-third of this hypotension at cesarean section. It can be diagnosed by hypotension, tachycardia, dy-

spnea and apprehension and treated simply by lifting the heavy uterus to the left or placing the patient on her left side⁹.

Treatment of hypotension which does not quickly respond to a trial of left uterine displacement should be with a rapid infusion of lactated Ringer's solution or five percent dextrose in water. We feel the known dangers of dextran solutions do not allow their routine use for this purpose, and generally plasma derivatives are too expensive. If hypotension persists despite this infusion for more than five minutes 25mg. intravenous ephedrine should be given.

Convulsions from Local Anesthetics

Maternal convulsions due to high blood concentrations of local anesthetics occur about once in every 125 caudal anesthetics for delivery; about once in 2,400 uses of local infiltration anesthesia¹⁰; and is definitely dose related. Treatment is with oxygen ventilation plus either succinylcholine or small divided doses of rapid acting intravenous barbiturates, along with constant appraisal of blood pressure.

Clinical experience shows that emergency, traumatic operative delivery of the baby in these cases is not indicated, providing maternal ventilation and blood pressure are maintained¹⁰. Recently basic research has substantiated these observations. The fetus is not able to detoxify many of the local anesthetic substances which he may receive from the mother across the placenta. Therefore, if the infant is delivered with a high blood level of local anesthetic drug he will have respiratory and cardiovascular depression. This situation has already been clearly demonstrated with toxic levels of a representative local anesthetic, mepivacaine in human babies at term gestation¹¹. Mepivacaine received by the baby just before birth is detoxified very slowly by the newborn. However, mepivacaine (and therefore probably other drugs) injected into the guinea pig fetus in utero disappeared at a more rapid rate due to reverse placental transfer into the mother¹¹. This demonstrates that, providing both mother and infant are stable, the longer the baby is left in utero after such an accident, the more of the drug will pass back into the mother as she redistributes and detoxifies it.

Similarly *accidental injection of local anesthetics* into the fetus during attempted caudal anesthesia has been reported but is

fortunately apparently extremely rare¹². This grave condition is often fatal due to the relatively large concentration of anesthetic thus achieved in the fetus and the inability of the fetus to metabolize the drug rapidly. Diagnosis can be made by the presence of extreme cardiovascular and respiratory collapse in the newborn when an attempted caudal has failed, particularly if a site of injection is identified¹². Treatment is with exchange transfusion and respiratory and cardiovascular support.

True allergy or sensitivity to these agents is a very rare cause of convulsions. Therefore, avoidance of dosage in excess of the recommendations of the manufacturer and care not to inadvertently inject the local anesthetic intravenously are the precautions necessary against convulsions in the mother. Care in placement of the needle during attempted caudal anesthesia, and a rectal examination while the needle is in place will prevent administration of the local directly into the baby.

Cerebrovascular Accidents

Convulsions due to cerebrovascular accidents can be precipitated by the concurrent use of catecholamines and ergot alkaloids, and this combination should be avoided. Synthetic oxytocin is the least likely of all such agents to cause such an accident. After this crisis has occurred, treatment is with narcotics and chlorpromazine to attempt to lower the blood pressure. Ganglionic blocking drugs may not be effective due to the peripheral site of the intense vasoconstriction which results from this combination¹³.

Primary cardiac failure under anesthesia accounts for 13 percent of maternal anesthetic mortality². The greatest danger period for cardiac patients is during the eighth month of pregnancy. However, a second danger period is during and immediately after delivery. Patients with functional cardiac disease class 2, 3, or 4 should not be allowed violent labor, exhaustion, or hypotension. Ergot alkaloids may dangerously accentuate the rise in venous pressure which normally follows delivery, and should be avoided. Treatment is by rapid digitalization, limitation of fluid intake, and diuretics.

Cardiac Arrest in the Delivery Room is fortunately a rare occurrence. Resuscitation after cardiac arrest in the adult has been the subject of extensive research in the past few years, and several excellent reviews are avail-

able on the subject¹⁴. In general, cardiac arrest occurring in the operating theatre or the delivery room has a most favorable prognosis with proper resuscitative efforts by the physician.

When cardiac arrest has been diagnosed by absent blood pressure and pulse, external cardiac massage should begin immediately. Coincident with the initiation of external cardiac massage, the airway should be cleared of foreign substances and should be adjusted to avoid obstruction. A second person in the delivery room should ventilate the patient with 100 percent oxygen, or with mouth-to-mouth ventilation, or with positive pressure room air via an AMBU bag, or by any one of the other available positive pressure breathing devices. Endotracheal intubation is not necessary, providing ventilation is adequate with mask administration of positive pressure breathing. Indeed, endotracheal intubation by an inexperienced person causing hypoxia and possible soft tissue damage is less desirable in this emergency situation. The key to adequate positive pressure ventilation without an endotracheal tube is in tilting the head backward (or extending the neck) to its maximum extent and elevating the mandible forward. This straightens out the passage for air into the trachea and removes the soft tissue obstruction of the tongue, in most instances. Positive pressure ventilation should be continued at least every five seconds during external cardiac massage. If only one resuscitator is present, he must not neglect to stop external massage every ten seconds to provide a maximal tidal volume to the victim.

External Cardiac Massage

External cardiac massage is carried out by placing the heel of one hand on the lower half of the sternum of the adult. The other hand is placed on top of this hand to add strength to the downward deflection. Pressure should be sufficient in the adult to compress the sternum toward the backbone one and one-half to two inches which, because of the valves in the heart, propels blood forward through the arterial system. This compression should be carried out sixty times a minute and not faster. A faster rate will not allow venous filling of the heart to be adequate for effective cardiac output. Pressure should be applied quickly in a squeezing motion and released instantly.

The weight of the resuscitator's body should be directly above the perpendicular drawn from the heart, in order that he can continue to apply pressure which has been estimated to be around 75 to 95 pounds for continued periods of time without tiring.

At the same time these maneuvers are being carried out, assistants or other resuscitators should be establishing a venous pathway either by needle or venous cutdown for the administration of important drugs, and electrocardiograph should be obtained and immediately applied to the patient. Drugs should be given for cardiotonic or vasopressor effects during true cardiac arrest and may be selected from the following groups:

epinephrine	0.5 mgm.
mephentermine	45 mgm.
ephedrine	25-50 mgm.
metaraminol	10 mgm.
levarterenol	0.5 mgm.
phenylephrine	2 mgm.

The use of these drugs is very important in order to strengthen the myocardial contractile force and to provide sufficient peripheral vessel resistance to create a blood pressure.

Perhaps the most important advance in resuscitation from cardiac arrest which has occurred in recent years is the more thorough understanding we have achieved of the importance of correction of the metabolic acidosis which develops during periods of poor circulation. A dosage of 44.6 mEq. venously about every five minutes of cardiac arrest. This will aid in maintaining a nearly normal pH of the blood and not only prevents weakening of the heart muscle from acidosis, but allows the heart to react normally to the drugs which are administered.

When the electrocardiograph is obtained and if spontaneous cardiac rhythm has not recurred in the meantime, it can be instrumental in determining the succeeding therapy. If there is asystole as shown by ECG, cardiotonic drugs such as 0.5 mgm. of epinephrine diluted to five or ten cc. should be administered directly into the heart by a puncture of the thoracic cage below the fourth rib and massaged into the coronary vessels. If there are regular ECG evidences of electrical activity but no palpable pulse, the failing circulation can be treated with the peripheral acting drugs, and perhaps repeated doses of sodium bicarbonate. If,

however, ventricular fibrillation is found to be present, only electrical defibrillation will be of assistance.

Electrical Defibrillation

Electrical defibrillation causes complete depolarization of the entire heart at the same time, allowing spontaneous resumption of the synchronous beats initiated by the sinoauricular node. Either the DC defibrillators or AC defibrillators may be used in the ordinary clinical situation. An AC shock should be administered which is 0.1 to 0.25 seconds in duration at five amperes with around 450 volts of power. Placement of the electrodes should be one just below the right clavical and the other over the apex of the heart. Great care should be taken that no other personnel receive this shock. In case the first shock is not sufficient, repeated shocks may be applied and higher voltage may be gradually used.

The DC type defibrillators usually use several thousand volts of power, and each of the several types of machines have different shock characteristics which should be studied before emergency use is necessary.

Efforts of resuscitation should cease if after an hour of adequate external massage, electrocardiographic evidences are poor, or there is persistent fibrillation with widened and nonreactive pupils, no spontaneous gasping movements, and no other signs of life.

External cardiac masage can lead to fractured sternum or ribs, trauma to the heart, liver, or spleen, pneumothorax and contusions of the lungs. These complications should be carefully looked for in patients who have been resuscitated from cardiac arrest.

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Psychotropic Drugs

By IRA S. HALPER, M.D./CHICAGO

INTRODUCTION

This paper is intended as a guide to the prescribing of psychotropic drugs. It is suggested that the reader choose a few agents for use with his patients and become thoroughly familiar with their effects and side effects. In line with this thinking, a relatively small number of drugs are discussed in this paper. For more information about these agents and for information about drugs that are not included, the reader is referred to the bibliography.¹⁻⁵

Bromides, paraldehyde and barbiturates have been used as sedatives for many years, and rauwolfia was used in India as far back as 1000 B.C. A new era of psychopharmacology began in 1952 with the introduction of chlorpromazine, a drug which had a potent tranquilizing effect in psychosis. In 1954 Kline reported the beneficial effect of reserpine in psychotic patients; and in 1957 iproniazid, a drug which had been used in the treatment of tuberculosis, was introduced as an antidepressant. The new drugs were greeted with great enthusiasm, and a large number of people turned to medication to relieve the tensions of everyday living. After about 10 years of experience, we can take a more balanced view of the tranquilizing and antidepressant drugs. Their contribution to psychiatry

should not be underestimated; it is substantial. On the other hand, the increased rates of discharge from mental hospitals are also due to changes in the direction of a more active, therapeutic milieu in these institutions. A certain amount of tension seems to be part of being human and seems to be necessary for psychological growth to occur. Many problems of living and learning will not be solved or dissolved by chemicals.

What is the place of psychotropic drugs in psychiatry today? On a basic science level, these agents have led to an increased momentum of research. Tranquilizers and antidepressants have a major place in the treatment of psychosis. This is particularly true in schizophrenia. Thought disorders, paranoid symptoms and withdrawal are affected as well as agitation. To a lesser but still significant extent, antidepressants are effective in the therapy of depression. The place of medication in the treatment of neurosis, situational reactions and personality disorders is less clear.

Now the severely ill patient need not be hospitalized. Patients have been on drugs as long as 10 years. They have not been deprived of intellect, responses to their surroundings, imagination or the ability to

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experience human emotions. The morbidity and mortality have been small. Some schizophrenic outpatients profit from long-term medication. Even though the patient is feeling better, continuation of the drug is indicated to avoid relapses. In brief visits at weekly or monthly intervals, medication can be prescribed and problems of current adjustment can be discussed. Drugs should be prescribed in collaboration with the patient, and the physician can be aware of underlying motivations and symptoms even though they are not explored with the patient. The physician should be aware that some patients fear drugs and will reject them even though pharmacological therapy seems to be a logical approach.

Drug studies vary in validity and reliability, and physicians should learn how to

critically evaluate the literature. Rating scales may be adequate or inadequate. Controls may be superficially introduced for decoration or may effectively control essential factors. Drugs may be administered in inadequate dosages or for inadequate periods of time. The attitude of the prescribing physician toward the medication is an important variable in evaluating a drug's effects.⁶ An enthusiastic attitude may produce a different result than a casual or a disparaging one.

In this paper the tranquilizers will be classified according to their predominant clinical use. The drugs for psychosis have been called major tranquilizers, and the drugs for anxiety have been called minor tranquilizers.

DRUGS FOR PSYCHOSIS

Phenothiazines

The phenothiazine drugs produce marked calming and tension-reducing effects. Drowsiness may occur initially but usually disappears. Adrenergic blocking effects and antiemetic effects are also seen. It is known that chlorpromazine alters the permeability of cell membranes and has potent effects on metabolic processes of organized membrane structures such as mitochondria;⁷ however, the mechanism of the tranquilizing effect is not well worked out.

The phenothiazines are effectively used in all non-depressive psychotic states and particularly in the schizophrenias. Depressions can be aggravated by phenothiazines. They have been used in delirium tremens, but severe and prolonged D.T.'s responds better to paraldehyde or chlordiazepoxide. Phenothiazines are not indicated in neurotic disorders and mild character problems.

A number of side effects have been reported. Some of these complications are: 1) Neurological. Parkinsonism with decrease in spontaneous motility, mask-like facies, rigidity and tremor is seen. Dyskinesias occur, including dystonia, akathisia and trismus. These symptoms usually respond to anti-Parkinson agents such as benztropine (Cogentin), 1 to 4 mg. once or twice a day; however, cases of persistent dyskinesias have been reported. Parkinsonism which appears soon after phenothiazine therapy has begun may be transient, and anti-Parkinson medication can be withdrawn after two weeks in some cases. La-

ryngospasm is uncommon but potentially dangerous. It responds to diphenhydramine (Benadryl), 25 mg. intravenously.⁸ Grand mal seizures have occurred in patients taking phenothiazines; some of these patients have no previous history of epilepsy. 2) Cardiovascular. Hypotension occurs, particularly with the first parenteral dose. Recovery is usually spontaneous. If specific treatment is indicated, phenylephrine (Neo-Synephrine) 5 mg. intramuscularly or the more potent levarterenol (Levophed) is recommended. Epinephrine may produce a paradoxical further lowering of blood pressure and should not be used. 3) Hepatic. A small percentage of patients develop cholestatic hepatitis, generally within the first three months of treatment. Pre-existing liver disease apparently does not predispose to this side effect. 4) Hematologic. Agranulocytosis is uncommon but dangerous. It usually appears within the first three months of treatment.⁹ Periodic blood tests do not insure against the development of this toxic effect, which may have a sudden onset. Attention should be paid to symptoms such as sore throat and fever. 5) Long-term side effects. Changes in skin color and melaninlike deposits in the lens and cornea have been noted in patients who have taken about 200 mg. of chlorpromazine daily, or a comparable dose of other phenothiazines, for a period of two years.¹⁰ Most of these patients have not had a reduction in visual acuity; nevertheless periodic slit-lamp

examinations are recommended in the long-term use of these drugs. 6) Differential side effects. Chlorpromazine seems to be associated with a higher incidence of jaundice and agranulocytosis. Extrapyr- amidal side effects are more likely to occur with trifluoperazine. Retinopathy has been seen in patients taking thioridazine in doses of 1600 mg. per day or more.² An in- hibition of ejaculation has also been seen in patients on thioridazine; orgasm occurs but ejaculation does not. Drowsiness may occur initially with all phenothiazines. It is more likely to occur with chlorpromazine than with trifluoperazine or thioridazine. At least a routine medical work-up is rec- ommended before prescribing phenothia- zine tranquilizers. The above list of side effects may look formidable. It should be remembered, however, that these drugs are used for serious and often crippling illnesses. Thus, some risk seems warranted.

Chlorpromazine (Thorazine) is pre- scribed in doses ranging from 25 mg. t.i.d. to 1500 mg. per day. Disturbed psychotic patients commonly require 200 to 800 mg. per day. In uncooperative patients and emergency situations, 25 to 50 mg. may be given intramuscularly, slowly and deep into the upper, outer quadrant of the but-

tock. Parenteral chlorpromazine is three times as potent as oral forms. Trifluopera- zine (Stelazine) is prescribed in doses rang- ing from 2 mg. b.i.d. to 40 mg. per day. It is recommended that prophylactic anti- Parkinson medication be given when 10 mg. per day or more is prescribed. Thiori- dazine (Mellaril) is prescribed in doses ranging from 25 mg. t.i.d. to 800 mg. per day. One-fifth of the maximum dose or less is commonly used for maintenance treatment with phenothiazines.

Rauwolfia Alkaloids

Reserpine is the best-known member of this group of drugs and has a marked calm- ing effect. The rauwolfia alkaloids are no longer as widely used in the treatment of psychiatric disorders as they once were. Phenothiazines are as effective or more ef- fective, and there is a danger of serious depressions occurring, particularly in hy- pertensive patients. Reserpine remains im- portant in research, however. The depres- sion that it induces may be a pharmaco- logic model of the naturally occurring dis- order. In animal studies it has been found that reserpine-induced sedation is associ- ated with a depletion of brain serotonin, norepinephrine and dopamine.⁷

DRUGS FOR ANXIETY

Meprobamate

Meprobamate has some calming effect in neurotic patients. Psychological and phys- ical dependence can be a problem, and withdrawal symptoms similar to those seen with barbiturates have been produced by doses of about 2400 mg. per day,¹¹ the up- per limit of the recommended dose.

Benzodiazepine Compounds

Meprobamate has been replaced in pop- ularity by chlordiazepoxide. Chlordiaze- poxide and diazepam, a related drug, have tranquilizing, anti-convulsant and skeletal muscle relaxant effects. They are effective in neurotic anxiety and situational reac- tions but not in psychosis. There is some indication that diazepam is slightly more effective than chlordiazepoxide as a tran- quilizer. Both agents seem to have some antidepressant properties. In high doses chlordiazepoxide is an effective drug in the treatment of delirium tremens. Since addiction can occur, its use in the long- term management of alcoholics carries some risk.

Serious adverse reactions with chlordia- zepoxide and diazepam are uncommon; although agranulocytosis and jaundice have been reported. Drowsiness and ataxia are the most common side effects; diaze- pam produces somewhat more sedation than chlordiazepoxide. Anticholinergic ac- tions have not been reported; however, it is advised that diazepam not be used in pa- tients with glaucoma.

Chlordiazepoxide (Librium) is pre- scribed in doses ranging from 15 to 100 mg. per day. Abrupt withdrawal after sustained high dosages, on the order of 300 mg. per day, can produce an abstinence syndrome, including convulsions; however, this is not a problem with usual therapeu- tic doses. Diazepam (Valium) is pre- scribed in doses ranging from 4 mg. per day to 40 mg. per day. Abrupt withdrawal after prolonged overdosage may produce an abstinence syndrome. Both chlordiaze- poxide and diazepam have a cumulative effect.

Recent *in vitro* experiment¹⁵ indicate

that chlordiazepoxide and diazepam can lead to chromosome breakage. It should be emphasized that this work is in its early stages, and its clinical significance is not known. Nevertheless, caution may be indicated in prescribing these drugs for patients, either male or female, in their reproductive years. Tybamate (Solacen), which shows promise as a drug for anxiety,

and which thus far has not been associated with addiction¹⁶ may be an appropriate substitute for chlordiazepoxide and diazepam on these patients. The suggested dose of Tybamate is 750 to 2000 mg. daily. Another recent study¹⁷ suggests a possible association between chlorpromazine and chromosome breakage. The clinical significance of this observation is not known.

GENERAL PRECAUTIONS WITH TRANQUILIZERS

Tranquilizers can produce an addictive effect with alcohol and other central nervous system depressants. Patients should be cautious about driving and other potentially dangerous activities requiring

alertness and coordination. Elderly patients are more likely to develop side effects. In these cases it is recommended that a small starting dose be used and that increases be made in small increments.

DRUGS FOR DEPRESSION

Monoamine Oxidase Inhibitors

Iproniazid and the other monoamine oxidase inhibitors produce behavioral excitation and an elevation of brain levels of serotonin and norepinephrine. This elevation of brain amines presumably results from the inhibition of deamination by monoamine oxidase.

These drugs are important in terms of an understanding of the biochemistry of affective disorders, but serious and sometimes fatal side effects have been associated with the use of monoamine oxidase inhibitors. Hepatocellular damage has occurred. Hypertensive crises have occurred in patients taking tranlycypromine (Parnate), often after the patient has eaten cheese. This may be related to tranlycypromine's inhibition of monoamine oxidases, which prevents the destruction of pressor substances such as tyramine which are present in cheese.² The combination of a monoamine oxidase inhibitor and imipramine has produced hypotension and death. A period of at least two weeks should intervene between the use of MAO inhibitor and an antidepressant drug of the imipramine group, and therapy should be initiated with a small dose.

Dibenzazepine Group

For clinical use, the monoamine oxidase inhibitors have been largely replaced by the imipramine group of compounds, which are effective antidepressants and safer as well. Imipramine is structurally related to the phenothiazines. It does not inhibit monoamine oxidase. Imipramine may act by diminishing the uptake of

norepinephrine by the cell membrane, possibly making more norepinephrine available at the nerve ending.¹²

This group of drugs is effective in the treatment of serious depressions. There is some hazard of serious toxic reactions; therefore, their use in milder depressions is not indicated. Amitriptyline may be slightly more effective in the treatment of depression than imipramine. Amitriptyline also has mild tranquilizing properties. Some success has been reported in the use of imipramine for the treatment of alcoholism.

As with phenothiazines, Parkinsonism, cholestatic jaundice and activation of seizures in epileptic patients can be seen. Agranulocytosis has been reported in a few cases. Anticholinergic side effects—constipation, blurred vision and dry mouth, are common but usually not serious. Anticholinergic effects can be dangerous, however, in patients with glaucoma or benign prostatic hypertrophy. Hypotension can be a problem, particularly in hypertensive or elderly patients. Myocardial infarction and arrhythmias have been seen occasionally. Some patients on these drugs become agitated, and manic and schizophrenic symptoms have been observed. A phenothiazine or chlordiazepoxide can be used in these cases along with the antidepressant. There is some evidence that imipramine has teratogenic effects; so there should be a compelling reason for the use of these drugs during pregnancy. Desipramine and nortriptyline are demethylated derivatives of imipramine and amitripty-

line respectively; they may act more quickly than the parent compounds. Like amitriptyline, nortriptyline has a mild tranquilizing effect. At least a routine medical work-up is recommended before one prescribes this group of antidepressants.

Hospitalization should be considered when a serious risk of suicide exists. When rapid relief of psychotic depression is required in such patients, electroconvulsive therapy is probably the organic treatment of choice.

Imipramine (Tofranil) is prescribed in doses ranging from 25 mg. t.i.d. to 250 mg. daily. Amitriptyline (Elavil) is also prescribed in doses ranging from 25 mg. t.i.d. to 250 mg. per day. The best results with imipramine and amitriptyline seem to be obtained with doses of 150-250 mg. per day, a level which can be reached gradually over a period of several days. Desipramine (Norpramin and Pertofrane) is given in doses ranging from 25 mg. t.i.d. to 200 mg. per day. After a satisfactory re-

sponse has been achieved, the dosage of these three drugs often can be reduced to a maintenance level of about 100 mg. per day. Nortriptyline (Aventyl) is administered in gradually increasing doses, starting with 10 mg. b.i.d. and ranging up to 100 mg. per day. The maintenance dose is about 50 mg. per day.

There is a lag in the onset of action of these drugs which varies from a few days to a few weeks. They should be continued for several months after optimal improvement has been noted to avoid the danger of relapse. Smaller doses are indicated for geriatric and adolescent patients.

Other Antidepressants

Amphetamines and methylphenidate (Ritalin) have been used in the treatment of depression, but the results have been unimpressive. Addiction and psychosis can occur with these drugs. Chlordiazepoxide and diazepam may have a place in the treatment of milder depressions.

PSYCHOTOMIMETIC DRUGS

Lysergic acid diethylamide (LSD), mescaline and psilocybin are similar in structure to norepinephrine and serotonin. They are of investigative interest because of their ability to produce hallucinatory experiences and other psychotic-like symptoms. Unconscious material emerges; awareness becomes vivid; the world is seen in new ways. Mystical or psychedelic ex-

periences are reported by enthusiastic users; however, "turning on" without medical supervision can have serious consequences. Psychotic symptoms can persist¹³ and suicide has occurred under the influence of LSD.¹⁴ Reports of a psychedelic experience leading to startling cures of alcoholism and neurosis require careful investigation.⁵

HYPNOTICS

Not all cases of insomnia call for hypnotic drugs. However, particularly in acute states, the judicious use of nighttime sedation may help the patient cope more effectively with his problems. It has been suggested that insomnia produced by anxiety responds better to hypnotic drugs than that produced by rage.⁵ Patients are often unaware of these underlying emotions.

The hypnotic drugs produce central nervous system depression which varies from slight sedation to coma depending upon the dose. Studies of the action of barbiturates indicate that their effect on the reticular activating system is important in the production of sleep.

Residual sedation or "hang-over" occurs with these drugs if a large enough dose is used. This may be a price the patient has

to pay for a sustained hypnotic effect. It should be noted that insomnia itself can lead to a "hang-over" of sorts the morning after a restless night's sleep. The importance of this side effect varies with the patient. Grogginess may be of more significance to a physician or a truck driver than to a hospitalized patient or a retired person. Paradoxical excitement is sometimes seen, particularly in aged patients and in the presence of pain. Hypnotic drugs have been held responsible for a few cases of thrombocytopenia, neutropenia and agranulocytosis. Skin reactions occur in some patients taking these drugs. Gastric distress can be a problem with chloral hydrate. Secobarbital and pentobarbital are commonly administered as capsules of the sodium salts. These should be swallowed

promptly with water; for if allowed to dissolve in the mouth, their alkaline contents may inure the mucous membranes. Severe pulmonary insufficiency is a contraindication to the use of hypnotics; patients with disorders such as pulmonary emphysema are often extremely sensitive to the respiratory depressant action of ordinary hypnotic doses. Barbiturates should not be used in patients who suffer from acute intermittent porphyria, as attacks of this disease may be precipitated. The dangers ascribed to barbiturates in patients with hepatic disease may have been over-emphasized; nevertheless, barbiturates should be administered with caution to patients with hepatic damage.

Barbiturate addiction is relatively common, and barbiturate intoxication is a leading cause of death by suicide. The search for safer hypnotic drugs has not been very successful, however. Overdoses of chloral hydrate and the newer drugs can produce death, and the mortality rate from glutethimide (Doriden) poisoning may be considerably higher than that seen in barbiturate poisoning. Psychological and physical dependence are seen with chloral hydrate and with the newer drugs.

Secobarbital (Seconal) and pentobarbital (Nembutal) are the two most popular barbiturates; they seem to be equal in ef-

ficacy. The hypnotic dose is 100 to 200 mg. Clinically significant withdrawal symptoms are seen when about 600 mg. are ingested daily for a period of a few months. The hypnotic dose of chloral hydrate is .5 Gm. to 2 Gm. Chloral hydrate has a shorter duration of action than the barbiturates. The ingestion of large doses of chloral hydrate can produce physical dependence. Methypylon (Noludar) is a newer drug which has a hypnotic effect comparable to that of secobarbital and pentobarbital. It is prescribed in doses ranging from 200 to 400 mg. An abstinence syndrome was reported in a patient who took 2.4 Gm. of methypylon daily.¹¹ Ethinamate (Valmid) is about as effective in inducing sleep as secobarbital or pentobarbital but has a shorter duration of action. Its rapid metabolism is responsible for a low incidence of aftereffects but a rather poor performance in maintaining sleep. It is recommended for persons who are unusually susceptible to "hang-over" from drugs which act for a longer period of time. Ethinamate is prescribed in doses of .5 Gm. to 1 Gm. An abstinence syndrome was reported when a patient using 13 Gm. of ethinamate daily was withdrawn from this drug. A patient with epilepsy who had been taking 4 to 5 Gm. of ethinamate developed an abstinence syndrome on sudden withdrawal.¹¹

THE SUICIDAL PATIENT

If there is a serious danger of a patient using drugs for a suicide attempt, he should probably be treated without drugs or treated in a hospital. Sometimes physicians rely on family members to be custodians of medication in such situations.

This does not insure the patient's safety. In one such case the medication was entrusted to the patient's husband. The husband "accidentally" left the pills where the patient could find them, and she swallowed the entire contents of two bottles.

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The Short Child

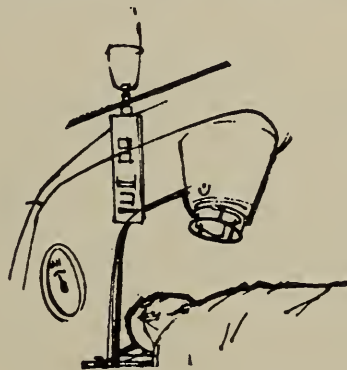
By MATTHEW M. STEINER, M.D./CHICAGO

The short child is under a great handicap in our modern culture which places such a premium on *tallness* particularly in males. The frustration of being shorter than one's peers is expressed in many ways both at home, at school, and in the environment. While this difficulty is not too manifest in the pre-school years, nevertheless, the "family runt" is looked upon with some concern especially when younger siblings grow taller and appear more vigorous. During the school years the short boy is exposed to recurrent experiences which often result in psychological trauma, and because of short stature, poor muscular development, and easy fatigue, he is kept out of many social and athletic activities. Thus many of these children gravitate to a younger age group with whom they are more comfortable physically, but who are less mature emotionally. The concern of the parents with their short child is manifested by the frequency with which the pediatrician or endocrinologist is consulted: "What can we do to make him grow"?

The major purpose of this discussion is to present a schematic and simplified clinical approach to the differential diagnosis of the short child. We will not include detailed descriptions of the myriad syndromes associated with retarded growth, or

present an exhausting evaluation of the many diagnostic procedures, or outline the many types of management for either endocrine or non-endocrine syndromes of growth retardation. The reader is referred to numerous texts and review articles for more detailed discussion.¹⁻⁶

Medical Progress



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Medical Progress Editor

We plan to present a panoramic view of major endocrine and non-endocrine syndromes associated with growth retardation; to stress basic history and physical examination as *the* essential clinical approach to



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the differential diagnosis; to minimize reliance upon hospitalization and the "laboratory work-up" except when these are necessary to pin-point specific etiological factors of growth defects; to emphasize the relative frequency and relationships of primordial dwarfism, constitutional growth retardation, and idiopathic hypopituitarism, and to discuss the laboratory tests available for their differentiation.

Tables I and II list the endocrine and non-endocrine syndromes associated with growth retardation. While the lists are by no means all-inclusive, they may serve as a useful guide to the initial clinical approach to the short child: namely, whether the problem is endocrine or non-endocrine, the relative frequency of endocrine versus non-endocrine factors, the relationship of various endocrine syndromes to the particular endocrine gland, and the inter-dependence of many diseases in the formation of discrete syndromes of growth retardation.

Basic History

Suggestions for pertinent history and emphasis on certain aspects of the physical examination to follow will apply mainly to the initial approach by the physician. Other suggestions and "clues" will be dealt with below under discussions of specific syndromes.

1. **ONSET OF GROWTH FAILURE AND GROWTH TRENDS:** Obtain height (and weight) measurements from birth and plot them on a percentile chart (Stuart or Iowa percentile tables).⁷⁻⁹ Variations in onset of growth failure and percentile growth curves will be discussed below under various syndromes as aids in the differential diagnosis.

2. **FAMILY HISTORY:** Outline heights of "family tree" and possible endocrinopathies. Note particularly growth trends and variations in adolescent or sexual development in grandparents, parents, siblings and close relatives. Familial, hereditary, or metabolic diseases should be ascertained.

3. **PREGNANCY AND DELIVERY:** Essential history for factors related to or associated with small-for-age babies or intra-uterine growth retardation, bleeding episodes, medications such as hormones, anti-metabolites, anti-hypertensives, or antibiotics for bacterial infections, and possible viral diseases (hepatitis, cytomegalic

inclusion disease, and rubella). Also note unusual birth, anoxia, respiratory distress, prematurity or post-maturity, and immediate post-natal experience.

4. **NEONATAL PERIOD:** Note birth weight and length in relation to period of gestation. (In general most newborn nurseries do not measure newborn length accurately unless this is done with a standard headboard in the supine position). Such incidents as anoxia, hemorrhage, infections, jaundice, hemolytic disease, and congenital anomalies may be helpful in relation to many non-endocrine syndromes.

5. **CHILDHOOD DISEASES:** Systemic diseases or chronic infections may be related to non-endocrine syndromes, and may in themselves serve as ultimate etiological factors in growth retardation.

6. **CHIEF COMPLAINTS:** The usual complaint will be "slow growth." It is also important to inquire about food intake, fatigue, morning weakness, hypoglycemia and/or convulsions. In a short child with a history suggestive of hypoglycemic episodes or convulsions, one should suspect hypopituitarism. In a group of 140 short children, the symptoms are listed in Table III. Slow growth, anorexia, fatigue, and poor weight gain were the most common findings. As a rule, slow growth had been going on for some time before the parents bring the child to the physician. If the patient is followed from birth, and particularly if there is some suspicious family history, one should become familiar with normal growth increments or employ a percentile growth chart to detect a "falling off" from normal growth curves. The psychological effects of being short, poorly developed, sexually retarded, and socially handicapped should also be investigated both with parents, school authorities, and the patient. Scholastic progress and environmental experiences may give some clues to various neurologic syndromes.

Basic Physical Examination

General appearance, alertness, facial configuration, and external anomalies may offer clues to defects associated with growth retardation.

1. **MEASUREMENTS:** Use of Stuart or Iowa percentile charts to plot heights and weights. Weight should be obtained on a beam scale without clothing. Height

should be measured without shoes and with the use of a right angle board against the vertical scale and head. Infants and young children are measured in the supine position with head against the right angle board and with the foot held at right angles with the palm of the hand at the other end of the scale. Relative proportions of the body and the ratio of upper (vertex or pubis) to lower (pubis to heel) parts of the body should be noted. These measurements are helpful in determining proportionate versus disproportionate types of dwarfism, e.g., skeletal or endocrine. The span of laterally extended hands should be measured from tips of fingers and compared to length of body. Likewise, circumference of head, chest, and abdomen should be noted.

2. PHYSICAL EXAMINATION: This

should include neurological examination and funduscopy. In males, size and circumference of the penis and length and width of testes should be noted. In females, development of breasts and external genitalia should be evaluated in comparison to chronologic age. In both sexes, unusual pigmentation, hirsutism, axillary, facial, or pubic hair should be noted. Abnormalities of long bones, carrying angle of elbows, short knuckles, and anomalies of the toes should be noted. (A ruler placed against the 5th, 4th, and 3rd knuckle should miss that of the index finger).

Endocrine Syndrome and Associated Glands (Table I)

I. APITUITARISM (Lorenzoni): This is a rare type of extreme dwarfism with chronic hypoglycemia and convulsions

TABLE I

<u>ENDOCRINE SYNDROME</u>	<u>ENDOCRINE GLAND</u>
I. APITUITARISM (Lorenzoni)	<div>CEREBRAL CORTEX</div> <div>HYPOTHALAMUS</div> <div>MEDIAN-EMINENCE GLAND</div> <div>PITUITARY</div>
II. CNS ANOMALIES, TUMORS, INFECTIONS	
Cerebral Dysplasia	
Cerebral Agenesis	
Fröhlich's Syndrome	
Lorain-Levi Syndrome	
Simmonds' Disease	
III. HYPOPITUITARY SYNDROME	<div>PINEAL</div> <div>THYROID</div> <div>PARATHYROID</div> <div>PANCREAS</div> <div>ADRENAL</div> <div>GONADS</div>
IV. EMOTIONAL DEPRIVATION AND/OR BATTERED CHILD SYNDROME	
V. INFANT HERCULES (MACROGENITOSOMIA PRAECOX)	
VI. CRETINISM JUVENILE HYPOTHYROIDISM	
VII. HYPERPARATHYROIDISM	
VIII. HYPOPARATHYROIDISM (Albright's Hereditary Osteodystrophy)	
IX. DIABETES MELLITUS	
X. ADDISON'S DISEASE	
XI. GONADAL DYSGENESIS	
XII. HYPERHORMONAL (SEX)	

which occurred in two siblings of apparently normal parents. In a post mortem study of one sibling, there was no recognizable pituitary gland, and there was atrophy of the thyroid, adrenal, and gonads.¹⁰⁻¹¹

II. CNS ANOMALIES, TUMORS, AND INFECTIONS: There are numerous syndromes in this group which can be differentiated on the basis of specific history and physical examination, particularly neurological examination. Cerebral dysplasia, cerebral anomalies, and agenesis also fall into this group. Historically, Fröhlich's syndrome¹²⁻¹³ and Lorain Levi types of dwarfism¹⁴ with sexual infantilism are also included here. It is well to recall that these latter two syndromes resulted from brain tumors in the region of the pituitary. Simmonds' disease¹⁵⁻¹⁶ is extremely rare in childhood, and neurologic findings may be associated with craniopharyngioma. Laurence Moon Biedl syndrome¹⁷ in its complete form is characterized by obesity, sexual infantilism, dwarfism, diabetes insipidus, mental defects, retinitis pigmentosa, polydactylism, and syndactylism. However, there are many incomplete types.

III. HYPOPITUITARY SYNDROME: There is great variation in the composition and expression of this syndrome depending upon the anatomic abnormality or involvement of the pituitary within the cerebral-hypothalamic-median eminence gland axis (CHME).¹⁸ Hence, cerebral anomalies, severe emotional disturbances, hypothalamic lesions, tumor or infections may influence the pituitary via the CHME axis. Most often the cause for hypopituitary syndrome is not known or "idiopathic." Total or pan-hypopituitarism is rare; most are relative or partial deficiencies with either defects of growth hormone alone (hyposomatotrophic hypopituitarism)¹⁹ or in combination with deficiencies of thyrotrophic (TSH), adrenocorticotrophic (ACTH), or gonadotrophic (FSH) hormones. For an excellent evaluation of 75 patients with hypopituitarism, the reader is referred to a recent paper from Johns Hopkins Hospital.²⁰

Except for retarded growth (height age less than chronologic age) the patient with idiopathic hypopituitarism may appear "normal." The dwarfism is generally proportionate; alertness and mentality are usually normal. The time of onset of growth retardation varies sometime after birth. The experience of hypoglycemia

and/or convulsions associated with growth retardation is viewed with suspicion but is not necessarily diagnostic of hypopituitarism. In the past, the diagnosis of hypopituitary dwarfism was either an "exclusion diagnosis" or was made after many years of patient observation. Recently, tests with metapirone, water diuresis, sulfation factor, and response of plasma growth hormone to insulin hypoglycemia or to arginine have made it possible to differentiate this "normal" short patient from other similar types to be discussed below.

IV. SEVERE EMOTIONAL DEPRIVATION AND/OR BATTERED CHILD SYNDROME: Recent attention to severely emotionally deprived children and to the battered child syndrome have focussed attention upon the growth deficit in such children. In addition, it has reemphasized the physiological and hormonal relationship of the CHME axis with the pituitary. These unfortunate children, respectively rejected or traumatized by parents or relatives, exhibit on history and physical examination a recognized syndrome: retarded growth, well-fed or malnourished or "battered" with abnormal drinking or perverse eating habits, large abdomens, steatorrhea, and speech defects. In Blizzard's report,²¹ some of these children had low fasting hormone levels, while others were normal. They did not however respond to insulin hypoglycemia. PBI tests were normal or low, and metapirone tests were normal or decreased. Hence, of this group many satisfied the criteria for hypopituitarism, and the use of human growth hormone would have been justified. However, without hormonal therapy, but with "tender loving care" and change of environment, their response in growth was remarkable indeed.

V. INFANT HERCULES (MACROGENITOSOMIA PRAECOX): This syndrome is included to focus attention upon the pineal gland.²² In males, some pineal tumors result in sexual precocity with marked muscular development and accelerated skeletal maturation. The resultant increase in linear growth is only temporary for, as the disproportionate skeletal maturation leads to premature closure of the epiphyses, growth ceases prematurely and short stature ensues. Other such syndromes associated with precocious sex development will be discussed below under "Hyperhormonal (Sex)."

VI. CRETINISM AND JUVENILE HYPOTHYROIDISM: Early detection and treatment of the cretin is of the utmost importance. It is well to "take a second look" at the newborn with hoarse cry, stuffy nose, dusky or mottled skin, and heart murmur. Too often it is the cardiologist who sees the cretin "too late" because of congenital heart disease. A history of thyroid disease in the family, anti-thyroid medication during pregnancy, or goiter in the newborn should also make one suspicious of possible thyroid failure. In the older child with juvenile hypothyroidism, it is well to remember that the syndrome takes *time* to develop. There may be insidious laziness, a lowering of school achievement, intermittent constipation, dryness of skin or hair, and unexplained anemia long before someone realizes that the child is not growing at a normal rate. A preceding thyroiditis may be responsible for a good number of cases of juvenile hypothyroidism.

VII. HYPERPARATHYROIDISM: This is extremely rare in childhood, and the growth deficit is a late manifestation of the disease. Some patients may exhibit a depressant neuromuscular syndrome with weakness, hypotonicity, gastrointestinal atony, anorexia, constipation, and loss of weight. Others may exhibit symptoms due to hypercalcemia and impairment of renal function with polyuria, polydipsia, and frequency. Renal calculi may give rise to hematuria, pyuria, and urethral obstruction. While the above symptoms may be present long before osseous changes develop and growth retardation ensues, such changes, however, may direct attention to the abnormal mineral metabolism in hyperparathyroidism.

VIII. HYPOPARATHYROIDISM: We are concerned mainly with pseudohypoparathyroidism and pseudo-pseudohypoparathyroidism in association with retarded growth. Fortunately, these are now known as Albright's hereditary osteodystrophy.²³ Such children are characterized by positive family history, short stature, stocky build, round facies, short metacarpal and metatarsal bones, mental retardation, calcinosis of subcutaneous tissues, exostoses, defective dentition, blue sclerae, and thick calvarium. There may also be "formes frustes" types with all or some of the presenting findings. In our study²⁴ of four such patients, we have encountered sixteen others reported

from ages four to 17 years. Short stature was present in 95 percent, short metacarpal and/or metatarsal bones in 95 percent, round facies in 65 percent, obesity in 55 percent, mental retardation in 55 percent, familial history in 55 percent, abnormal electroencephalogram in 30 percent, metastatic calcification in 10 percent, convulsions in five percent, and lenticular opacity in five percent. Exostoses is rarely encountered in the pediatric age group.

IX. DIABETES MELLITUS: Some children with diabetes who are either poorly controlled with insulin or who are on inadequate diets will exhibit retarded growth. Again, the effect upon growth comes on long after poor control and management in the known diabetic.

XI. ADDISON'S DISEASE: This disease is quite unusual in childhood. There may be lassitude, constipation, marked loss of weight, marked anorexia, growth failure, and skin pigmentation. The onset may be quite insidious, and there may also be a history of anoxia at birth with possible damage to the adrenal gland. In one of our patients²⁵ the mother reported that during the summer he had developed excessive "tan" which did not fade during the fall, and was associated over many months with fatigue and loss of weight. Another patient developed anorexia, fatigue and weakness without pigmentation of the skin.

XI. GONADAL DYSGENESIS: Inquiry of the infant's condition at birth is important: swellings of neck, hands or feet may be indicative of Bonnevie-Ullrich syndrome.²⁶⁻²⁸ The redundant type of neck may become transformed into the webbed neck which serves as a further clue to Turner's syndrome.²⁹ In such infants buccal smears for sex chromatin should be done at one to two month intervals and, if the smear is "negative," the diagnosis of gonadal dysgenesis can be made.³⁰ Typical chromosome studies of such children yield an XO karyotype. Also, female infants with coarctation of the aorta or subaortic stenosis with hypertension should have buccal smears for sex chromatin since this may be a variety of Turner's syndrome. During childhood, all short girls should have buccal smears particularly if epiphyseal development is not markedly delayed in comparison to the chronologic age. The typical patient is short with characteristic facies,

low-lying ears, webbed neck, low hair line, high arched palate, shield-like chest with widely spaced nipples, increased carrying angle of the elbows, and cardiac anomaly. Frequently, these children have short, small fingers and toes, syndactaly, and hallux valgus. Fingernails are often hypoplastic, small, thin and narrow. In addition, there may also be mosaic types with variants of this syndrome³¹ (XO/XX karyotype) and even with menses. To make matters more confusing, Turner's syndrome has been reported in males.³⁷

XII. HYPERHORMONAL (SEX): This is really a syndrome of "convenience" and

refers to the resultant dwarfism in patients with primary sex precocity which is quite evident. The latter may originate from disturbance of the CHME axis, pituitary, pineal, adrenal or gonads.

Non-Endocrine Syndromes (Table II)

I. SKELETAL: These children have characteristic disproportionate dwarfism and/or skeletal deformities which may be familial or hereditary. Various types include chondrodysplasia, Morquio's disease,³³⁻³⁴ gargoylism,³⁵⁻³⁶ osteogenesis imperfecta,³⁷ osteoporosis, rickets, diastrophic dwarfism,³⁸ and Ellis-Van Crevald syndrome.³⁹

TABLE II

NON-ENDOCRINE SYNDROMES

- I. **SKELETAL** — Chondrodysplasia, Gargoylism, Osteogenesis imperfecta, Osteoporosis, Morquio's disease, Rickets, Diastrophic dwarfism, Ellis-Van Crevald syndrome.
- II. **NUTRITIONAL** — Malabsorption syndrome, chronic enteritis, ulcerative colitis, uncontrolled vomiting and/or diarrhea.
- III. **METABOLIC** — Inborn errors of metabolism, Vitamin D resistant rickets, de Toni-Franconi syndrome, renal tubular acidosis, aminoaciduria, hypercalcemia, hypophosphatasia, galactosemia, glycogen storage disease.
- IV. **SYSTEMIC DISEASE** — Cardiac, pulmonary, hematologic, hepatic, biliary, renal, neoplastic.
- V. **INTRA-UTERINE GROWTH RETARDATION** — (1) **GENETIC** (dominant or recessive) Bird-head dwarf (Seckel), Bloom's syndrome, Cornelia de Lange syndrome, Lejeune catcry syndrome, Trisomy 18 syndrome, Russell-Silver syndrome.
(2) **NON-GENETIC**—Prenatal X-ray with microcephaly, maternal Vitamin A deficiency, Rubella syndrome, Folic acid deficiency, antimetabolite therapy, placental immaturity syndrome, severe hypoxia, cytomegalic inclusion disease.
- VI. **IATROGENIC DISEASE** — Long term steroid therapy.
- VII. **PRIMORDIAL (GENETIC) DWARFISM.**
- VIII. **CONSTITUTIONAL GROWTH RETARDATION.**
- IX. **MISCELLANEOUS** — Progeria, progeroid syndrome, Leprechaunism, chromosomal aberrations, Hallermann-Strieff syndrome, syndrome of Rubinstein and Taybi, Cockayne's syndrome.

II. NUTRITIONAL: There is a definite history of previous chronic illness, and the growth retardation is a late manifestation of the disease. One can include here malabsorption syndromes (coeliac and fibrocystic disease), chronic enteritis, ulcerative colitis, uncontrolled vomiting and/or diarrhea, and practically any condition which results in severe prolonged caloric deficit.

III. METABOLIC: A detailed history of the specific disease is essential. Most likely laboratory work-up for the disease will have been instituted for many of the symptoms since, again, growth retardation is a late manifestation of metabolic diseases. Detailed family history is important because of familial incidence with dominant and recessive gene patterns. In fact, one can include here various inborn errors of metabolism, vitamin D resistant rickets, de Toni-Franconi syndrome, renal tubular acidosis, aminoaciduria, hypercalcuria, hypophosphatasia, galactosemia, and glycogen storage disease.

IV. SYSTEMIC DISEASE: Practically any chronic systemic disease can eventually affect growth. A detailed history and laboratory work-up for the specific symptoms will often precede the late appearance of growth retardation.

V. INTRAUTERINE GROWTH RETARDATION: The family history as well as a detailed analysis of the pregnancy are important. Birth weight in relation to length of gestation; examination of the placenta for abnormal weight, infarcts, infection, or defects in morphology; anomalies of umbilical cord (single artery), and congenital anomalies of the newborn infant—all constitute a studious approach to this large problem. Anomalies of the placenta with intra-uterine growth retardation are often associated with both genetic as well as non-genetic factors. Some of the possible genetic (dominant or recessive) expressions are bird-head dwarf (Seckel),⁴⁰ Bloom's syndrome,⁴¹ Cornelia de Lange syndrome,⁴² Lejeune cat-cry syndrome,⁴³ Trisomy 18 syndrome,⁴⁴ and Russell-Silver syndrome.⁴⁵⁻⁴⁶ On the other hand, prenatal X-ray with microcephaly, maternal vitamin A deficiency, Rubella syndrome,⁴⁷ folic acid deficiency, anti-metabolite therapy, placental immaturity syndrome, severe hypoxia, and cytomegalic inclusion disease represent some of the non-genetic factors.

VI. IATROGENIC DISEASE: This refers mainly to the growth retardation resulting from the use of steroids (dexamethasone and cortisone derivatives) in long term therapy for such conditions as female pseudohermaphroditism, chronic asthma, nephrosis and rheumatoid arthritis.

VII. PRIMORDIAL (GENETIC): There may be a history of hereditary transmission through normal as well as dwarfed members of the family. As a rule, the term infant is usually but not always small at birth. The child eventually develops into a miniature normal adult with normal sex development; the dwarfism is proportionate. Hence, on the basis of history and physical examination, this type is the second example of a child who is short but otherwise "normal."

VIII. CONSTITUTIONAL GROWTH RETARDATION WITH DELAYED ADOLESCENCE: This is the most common type of retarded growth in children, and accounts for about 70 to 75 percent of all the short children in our experience.⁴⁸ Aside from short stature, which is proportionate, there are no unusual findings on physical examination. Hence, this type represents the third form of "normal" short child. Birth weight is usually normal, and the length may or may not be below usual. In general growth retardation is noted after age 18 months or it may develop at any time in the prepuberal period. There may be a familial pattern in such families with both short and tall people, and even similar short siblings.

In a group of 112 patients, there were 98 males and 14 females (the greater proportion of males reflects the greater concern with short males in society). Forty-four percent were seen during the preschool years, 43 percent between ages 6 and 12, and 13 percent between ages 12 and 16. Slow growth, anorexia, easy fatigue and poor weight gain were the most common complaints. However, poor weight gain and fatigue were not always associated with growth retardation. Prominent in the male group aged 10 to 13 was the feeling of being inferior and different: "They call me runt," "I get left out of dances and games," "I am the shortest of the class," and "I am ashamed to take a shower in gym or go swimming because I am so small (genitals)." No relationship was evident

TABLE III
SYMPTOMS IN 240 SHORT CHILDREN

Slow Growth	100 per cent
Anorexia	94 per cent
Fatigue	68 per cent
Poor Weight Gain	64 per cent
Psychologic	25 per cent
Morning Weakness	13 per cent
Retarded Puberty	7 per cent
Convulsions	5 per cent

between the heights of the patients and the type of pregnancy, labor, delivery, or length of gestation. Birth weight, type of feeding, post-natal complications or infections did not appear to contribute to the retarded growth. The approximate time of onset of growth retardation could not be ascertained except by such factors as changes in size of clothing or shoes, relation to height of younger sibling, and size in line-up at school. When heights were obtained from birth (accounting for error in nursery measurement) and plotted on the Iowa percentile chart, the heights fell below the 10th percentile anywhere from age six months to 10 years.

At the first examination, the heights were between the 3rd and 10th percentile in 86 percent, and below the 3rd percentile in 14 percent. Depression of height age (height of patient projected onto 50th percentile) below chronologic age was determined for all patients. Twenty percent were 0 to 1 year behind, 34 percent between 1 and 2 years, 25 percent between 2 and 3 years, 10 percent between 3 and 4 years, and 9 percent between 4 and 5 years behind the chronologic age. Skeletal proportions were noted to be proportionate (ratio of upper to lower segments retained the more mature proportion consistent with their chronologic

age). Likewise, the span of outstretched hands was within normal limits for the height. Most patients exhibited a thin habitus with poorly developed musculature. During the pre-puberal period, there was no consistent relationship of genital development to chronologic age among the males. However, delayed maturation and growth of external genitalia was unmistakable in the post-puberal males. Anxieties of male identification and evidence of psychological trauma were more often seen in this group of males.

IX. MISCELLANEOUS: Many odd and bizarre types of dwarfism are included in this group: progeria,⁴⁹ progeroid syndrome,⁵⁰ Leprechaunism,⁵¹ chromosomal aberrations,⁵²⁻⁵³ Hallermann-Strieff syndrome,⁵⁴ syndrome of Rubinstein and Taybi,⁵⁵ Cockayne's syndrome,⁵⁶ and many more to be added in the future.

Basic Laboratory and Differential Diagnosis:

These laboratory tests have been reserved mainly for the differential diagnosis of the "normal" short child, namely, idiopathic hypopituitarism, primordial dwarfism, and constitutional growth retardation. For the sake of economy and avoidance of the "complete work-up" in the hospital, the initial laboratory tests can be performed as an out-patient.

1. X-ray of hemiskeleton for bone age.
2. Lateral view of the skull for sella turcica.
3. Blood chemistry: fasting glucose, urea nitrogen, and cholesterol.
4. P.B.I. or true thyroxin level.

Differential Diagnosis (Table IV)

1. BONE AGE. This simple test can differentiate between primordial dwarfism and

TABLE IV
DIFFERENTIAL DIAGNOSIS

	BONE AGE	PBI	METOPIRONE	GROWTH HORMONE RESPONSE
Primordial Dwarfism	BA = CA	Normal	Normal	Normal
Constitutional Growth Retardation	BA < CA	Normal	Normal	Normal
Idiopathic Hypopituitarism	BA < CA	Normal or Below Normal	Decreased	No Response

both constitutional growth retardation or idiopathic hypopituitarism. The bone age will be normal in the primordial dwarf whereas it will be below the chronologic age in the other types. The sella will be normal in all three types.

2. PROTEIN BOUND IODINE: This test aids in the differential diagnosis between idiopathic hypopituitarism and constitutional growth retardation but does not necessarily make the diagnosis. In constitutional growth retardation, in addition to the bone age being below the chronologic age, the P.B.I. is always normal. In idiopathic hypopituitarism, the P.B.I. can be normal but is generally low. It is of some interest that despite a low P.B.I. in the latter type, clinical myxedema is generally absent, and these children appear "normal" as mentioned above. Again, in the presence of a normal P.B.I. and retarded bone age, the height of the child with idiopathic hypopituitarism will generally be far below the 3rd percentile (or 3 to 4 standard deviations below the mean, and the growth curve will not follow a definite curve at any percentile. A word of caution about P.B.I. tests in general. The laboratory at which the test is done should be reliable and experienced (We send our tests to Bio Science Laboratory, Los Angeles, Calif.), and one should be aware of the many agents and drugs which interfere with or alter the interpretation of the test.

3. METAPIRONE TEST: This test should be performed under hospital supervision if possible, but it can be done as an out-patient at home if accurate urine collections can be assured. Fifteen mg/kg/per dose of metapirone is given every four hours for six doses. A 24-hour urine collection is obtained the day before, on the day of administration of metapirone, and on the day after the test. The urine is assayed for 17-KS, 17-OHCS, and THS.

The metapirone test is designed to determine whether the hypothalamic-pituitary mechanism responsible for the secretion and release of ACTH is intact. Metapirone specifically blocks 11-hydroxylase enzyme necessary for the synthesis of cortisol by the adrenal gland. In the absence of this enzyme, Compound S is formed but cannot be converted to cortisol. Because of the decrease of circulating cortisol, the normal inhibition of the pituitary is released, thus

permitting ACTH to be secreted in greatly increased amounts. This in turn stimulates the adrenals to secrete greater quantities of Compound S, which has only little effect upon suppression of ACTH secretion. The latter steroid is measured in the urine as 17-OHCS and THS. Normally, the 17-OHCS level on the day following metapirone increases two and one-half to six times control levels. In hypothalamic or pituitary defects preventing the secretion of ACTH, the expected increase of 17-OHCS does not occur. Hence, in the differential diagnosis, the metapirone test is useful in distinguishing mainly between idiopathic hypopituitarism and constitutional growth retardation.

4. GROWTH HORMONE RESPONSE: This test measures the response of growth hormone to insulin hypoglycemia. It is *definitely* a hospital procedure by trained medical personnel who are prepared to recognize and treat possible insulin sensitivity and extreme drop in blood glucose and/or hypoglycemic convulsions. Neither is the assay of growth hormone a "routine" laboratory procedure but rather one which should be reserved for making a critical diagnosis after other less involved tests have been done in the differential diagnosis of the short child.

The procedure consists of administering regular insulin (0.5 units/kg) intravenously at 9 a. m. (NPO after midnight). Blood is drawn before, at 30 minutes, and at 60 minutes after insulin injection; the blood is assayed for glucose and growth hormone. In the normal child, which includes primordial dwarfism and constitutional growth retardation, the levels of growth hormone at fasting range from 0 to 7.6 mg/ml plasma with a mean of 2.5 mg/ml. At 30 minutes, the range is from 11.5 to 54.1 with a mean of 24.0 and at 60 minutes the range is from 0 to 69 with a mean of 12.8 mg/ml. In a group of patients with constitutional growth retardation, the mean levels of growth hormone at fasting, 30 and 60 minutes were 2.2., 28.3 and 20.8 mg/ml respectively. In a group of children with definite hypopituitarism, no levels of growth hormone were detected following insulin hypoglycemia.

Summary

The purpose of this discussion is to stress basic history and physical examination as *the* essential clinical approach to the differ-

ential diagnosis of the short child; to minimize the need for initial hospitalization or extensive laboratory "work-up" except when these are necessary to pin-point specific etiologic factors responsible for growth retardation.

Major endocrine and non-endocrine syndromes associated with retarded growth are outlined in simplified, schematic Tables. The reader is referred to numerous texts and review articles for detailed descriptions, diagnostic procedures, and management of

the various syndromes listed in the Tables.

One of the major results of this clinical approach is the differentiation of the short child, who is otherwise "normal," from other endocrine and non-endocrine syndromes. The retarded growth in such a short child may be due to idiopathic hypopituitarism, preimordial dwarfism, or constitutional growth retardation. A discussion of the laboratory tests available for differential diagnosis is given in some detail.

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(Continued on page 59)



THE VIEW BOX

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Fig. 1

This 15-year-old Negro male entered the Endocrine Clinic of the Cook County Hospital because his mother had noted a "peculiar appearance of his hands and feet" which she felt had gotten worse in the last few years. A systolic murmur was heard over the apex. His height was 55 inches. A calcium level was 9.0 mg. percent. Phosphorus, 4.0 mg. percent.

WHAT'S YOUR DIAGNOSIS?

- 1) Pseudo hypoparathyroidism
- 2) Turners syndrome
- 3) Fanconi syndrome
- 4) Residual sickle cell dactylitis

(Answer on page 112)



Fig. 2

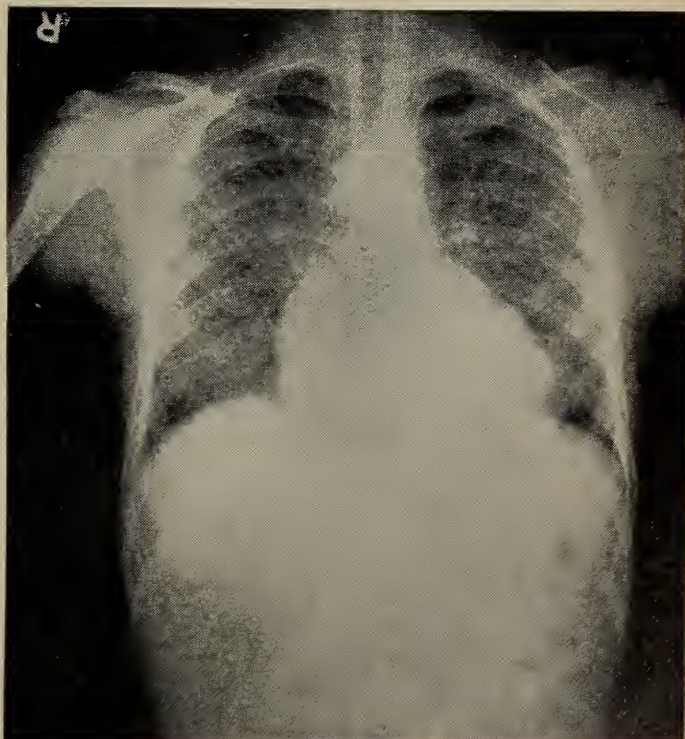


Fig. 3

Treatment of Varicose Ulcers

JOHN W. CURTIN, M.D., F.A.C.S./CHICAGO

The numerous methods and the many failures in the past bear silent witness to the difficult nature of the "stasis ulcer" problem. One needs only to be reminded of his last visit or ward rounds at his local University, Veterans or County Hospital to refresh his memory of this ever present, chronic, bed filling disability. With the advent of Medicare the local community hospital may also find its bed occupancy with this type of patient greater than it had wished.

It must be remembered that it is essential at the outset to determine whether the leg ulcers are of the stasis type due to venous insufficiency or due to ischemia as the result of arterial insufficiency. Too often treatment has been ineffective because attention was focused on the ulcer only, while the stasis and underlying chronic venous or arterial insufficiency were overlooked.

The stasis which results from the abnormally high ambulatory pressure in chronic venous insufficiency manifests itself pathologically by changes in the skin and subcutaneous tissues around the distal one-third of the leg and around the ankle—that is the "ulcer bearing area" of the lower extremity. These changes occur more often on the medial than on the lateral aspect of the leg and ankle (Figs. 1 and 2). They in-

clude edema, pigmentation, dermatitis, induration, sometimes stasis, cellulitis and ultimately—stasis ulcer. The ulcer is often associated with underlying deep venous insufficiency as well as incompetent perforating and superficial veins that many times lead into the area of the lesion and significantly contribute to the congestion in the superficial tissues. Stasis ulceration is an uncommon complication of primary varicose veins except when trauma or erosion of a small varicosity through the overlying skin has occurred.

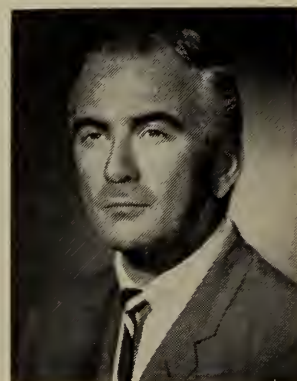
Cause

Cockett's theory¹ is that all venous ulcers and induration of the lower leg are usually due to destruction of the valves in the ankle perforating veins. The commonest precursor of the lesion is a spray of fine dilated venules which spreads over the inner surface of the ankle, behind the malleolus and flares out to be lost in the thick skin of the heel pad — "ankle flare."

Once the stasis ulcer has developed, it usually heals slowly because of local congestion although periods of remission are common.

The onset of the ulcer may be spontaneous or it may be precipitated by minor trauma such as scratching, bruising or kicking. Mild secondary infection from the

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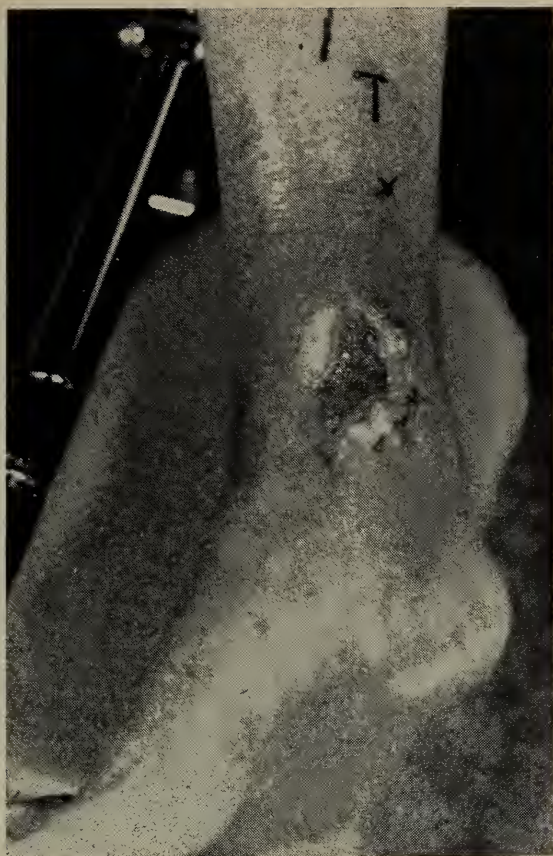


Fig. 1

mixed flora of the surrounding skin is usually present. The superadded factor of infection often creates scar tissue and fibrosis in the margin which further impedes the healing process.

However initiated, varicose and post-phlebitic ulcers are similar in appearance. A pattern of ulceration, healing with scar tissue, trauma and recurrent ulceration occurs resulting in continuous enlargement of the original ulcer site.

Conservative Treatment

The basic principle in the treatment of the stasis ulcer is to relieve the stasis — then the lesion will heal. If the ulcer is small or shallow it usually heals with ordinary supporting measures.

The most conservative management of these ulcers consists in:

1. Education of the patient in the details of applying elastic bandages.
2. Encouragement of movement and exercise of the leg and calf.
3. Avoidance of all irritating applications to the ulcer site.

We advocate:

- a. Zinc oxide cream or an antibiotic ointment to ulcer and cocoa butter



Fig. 2

- or olive oil to surrounding skin.
- b. Dry fine mesh gauze over ulcer (no Telfa).
- c. Soft felt pad to extend out to cover perforating veins.
- d. Crepe bandage and finally an elastic bandage making positive that pressure is provided below malleoli.

Other non-surgical management consists in the use of Elastoplast boot — a modification of the Unna paste boot. It is less cumbersome to apply and just as effective and made up of:

1. Sterile fine mesh gauze impregnated with zinc oxide and glycerine and cotton padding over the ulcer site.
2. Foam rubber pad to extend and overlap and cover the perforating veins.
3. Elastoplast bandage applied evenly but not tightly from the distal $\frac{1}{3}$ of the foot to just below the knee. A heavy elastic bandage is applied over the elastoplast bandage to reinforce the compression exerted. The boot is removed and re-applied every 10-12 days until the ulcer is healed.

This form of therapy suffers certain disadvantages however.

- 1st. It necessitates unremitting care in application of bandages and stockings for the rest of the patient's life. If vigilance is relaxed there is every likelihood of recurrence.



Fig. 3



Fig. 4

2nd. Pads and stockings are bulky, uncomfortable in hot weather and many patients (particularly younger ones) are intolerant of them.

3rd. Some ulcers, particularly post-thrombotic ones, escape control and are never completely healed.

This latter method is reserved for those cases in the upper age group or for those who do not wish operative treatment.

Surgical Management

Ulcers are amenable to surgical therapy with a reasonable hope of permanent cure only at a relatively early stage of their natural history. Once the condition has been present for 15-20 years and the whole of the lower third of the leg is a mass of indurated fibrous tissue then ligation of veins is unlikely to effect the lesion greatly.

The aim of treatment is to obtain a closed wound by excising the heavily scarred tissue and replace it with pliable functional skin. Such therapy thus interrupts the vicious circle of ulceration, infection, edema, fibrosis and ischemia, all of which tend to the reformation of the ulceration.

Before any type of skin graft can be executed successfully, adequate preoperative

preparation must be given. Bed rest and elevation of the extremities will reduce edema and inflammatory reaction about the stasis ulcer. Local mechanical wound cleanliness creates the optimal environment for the growth of healthy granulation tissue and minimizes bacterial contamination. Bi-daily dressings with debridement of necrotic tissue is the most effective way to clean and prepare the wound. We are not enthusiastic about enzymatic debriding agents and feel mechanical debridement is more effective.

It is probably best not to do fasciotomies until the ulcer has changed from an indolent one to a healing one. This is noted by a beefy red finely granular tissue base, lack of induration and tenderness of the surrounding tissues and the formation of a narrow blue rim of ingrowing epithelium.

Finally the chronic ulcer (Fig. 3), along with all adjacent and underlying necrotic tissue and scarring must be excised widely. The level of excision must be carried back to what appears to be adequate blood supply as noted by local bleeding and absence of further fibrosis (Fig. 4). An ulcerating area, unable to hold its own skin, cannot be expected to nourish a skin graft

or pedicle flap until the basic underlying circulatory factor is corrected or that surgical excision has found a level of good blood supply. In marked chronic ulceration removal of the underlying deep fascia is mandatory. The layer or paratenon overlying tendon and muscle should be left so they are not exposed.

A straight incision above and below the ulcer is advocated for exposure of the internal perforators. The incision is carried down to the deep fascia. If there is an ulcer or healed ulcer in this doubtful area of skin in the line of incision, that area is excised enroute. All small and large perforators are found and carefully followed

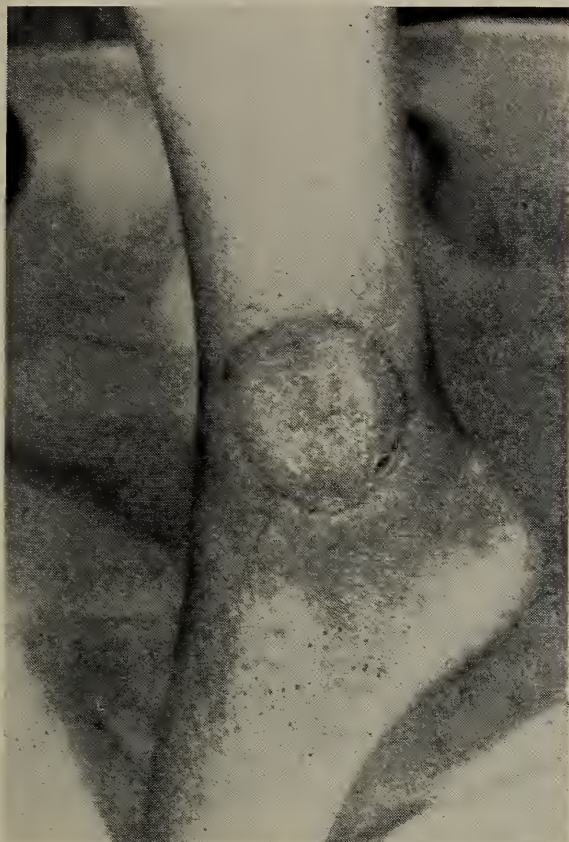


Fig. 5



Fig. 7



Fig. 6

and ligated. The Linton procedure is similar but a more extensive subfascial dissection of communicating veins is done followed by removal of a large sheet of fascia.

It is true that fresh surgical wounds make the most ideal base for the application of a skin graft of any variety. However, in the excision of such old fibrotic ulcers uncontrollable capillary bleeding is usually the rule. Immediate skin grafting would certainly be complicated by hematoma and we favor waiting at least 24 hours before applying a skin graft over these defects.² Our over-all success has been greater, however, by waiting from seven to fourteen days for such areas to develop sufficient vascular granulations so that when a split-thickness skin graft is applied, we can be assured of a complete growth (Figs. 5, 6, 7).

Finally we have no hesitancy in inspecting a skin graft in 24 hours or sooner if we suspect potential complications. We find ourselves dressing our skin grafts earlier and earlier and to date have never regretted doing so. This has resulted in the salvage of many a graft under which was found a hematoma, seroma, collection of pus or thin organized layer of fibrin. A drainage

opening in the graft immediately overlying this area with evacuation of serum, blood clot or fibrin film will save that portion of the graft which would otherwise have been lost. This is a more sound procedure than the old piecrusting routine which is effective for as long as it takes the blood or serum to clot, i.e., a few minutes.

Conclusions

1. Venous (VARICOSE) ulcers are the most common type of ulcer seen in medical practice and are most often found on the medial aspect of the distal third of the lower extremity.

2. Ordinary supportive measures will heal most shallow ulcerations.

3. Successful surgical management consists in correction of underlying chronic venous insufficiency followed by removal of the chronic ulcer and adjacent involved tissues. Delayed skin grafting has given uniformly better results in most cases.

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THERAPEUTIC EXERCISE

The development of therapeutic exercise as a modern science dates to the publication in 1866 in France of the now classic work of Guillaume Benjamin Duchenne, *Physiology of Motion*. In describing the action of the superficial muscles of the body, Duchenne stated, "A knowledge of the muscular mechanism leads to a rational treatment of paralysis, atrophies, and deformities by application of special local peripheral stimulation, physical and physiologic prosthesis."

Emanuel B. Kaplan, in the foreword of the first translation of this French work in 1949, suggested that

This book may be placed among the greatest books of all times — not on account of its historical significance — but, because it contains an excellent record of the kinesiology of the entire muscular system — investigated by one observer whose genius, perseverance and originality permitted him a deeper insight into the action of muscles than given to his many predecessors and, perhaps, more modern investigators.

Each system of the body has its own particular function. The musculoskeletal system must provide motion and stability. In order that the body function with the greatest efficiency, there must be both a source of power and a control of the rate of speed and the distance through which the power is used.

Principles of Therapeutic Exercise and Muscle Re-Education. Howard A. Rusk, M.D. Rehabilitation Medicine. Second Edition. Chapter 4.

Pediatricians Recommend Using Only Live Measles Vaccine

The American Academy of Pediatrics has recommended that inactivated (killed) measles vaccine no longer be used, and that live, attenuated measles vaccine be given as soon as possible to children who may have received only the killed type of vaccine.

In a statement appearing in the Academy's (Nov. 15) *Newsletter*, the AAP Committee on Control of Infectious Diseases also suggests that parents be cautioned about possible local and systemic reactions which may occur when children who have received the killed vaccine are later exposed naturally to measles.

These reactions can include an atypical rash that begins on the feet and spreads upward, high fever, edema, and pneumonia.

The statement also points out that some children who have received the live, attenuated form of vaccine following inoculation with the killed type, have experienced heat, tenderness, swelling of the lymph nodes, and malaise.

A third recommendation calls for children who have underlying illness, or who receive

forms of therapy which may render inadvisable the use of live vaccines, to be given immune globulin (human) "for protection on exposure to measles."

The Academy statement emphasizes that the magnitude and incidence of these reactions must still be determined.

But in one town, 11 of 66 children developed abnormal illness when exposed to natural measles "four years after administration of inactivated vaccine."

In another area, nine of 31 children had local reactions when given live vaccine "one year after a course of inactivated antigen."

"Reactions of this sort have not been observed with live, attenuated virus vaccine or natural measles unless prior sensitization had been induced by the inactivated vaccine," the statement concludes. Although the development of these reactions has not been fully clarified, "their severity and frequency, and the likelihood that less overt, unrecognized forms may occur, justify a reconsideration of the use of this vaccine at this time."

The Short Child *(Continued from page 52)*

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The Outlook of Industrial Hygiene in Illinois

By JEROME T. SIEDLECKI/CHICAGO

The lack of adequate occupational health services in small plants was emphasized in the 1939 survey of industrial hygiene problems in Illinois.¹ The situation has not changed. Many of the larger plants, and even the small plants of the larger multi-plant companies, have established occupational health programs which have included industrial hygiene. Occupational diseases in these plants have become a very minor cause of illness and absenteeism. These plants are on top of the job.

We should be concerned with those plants which do not have occupational health programs and which are not fully aware that the occupational hazards, inevitable in some industries, are preventable. It is in these plants that absenteeism caused by occupational disease is high.

Most of these plants are small and do not, and cannot be expected to employ professional people, knowledgeable in environmental health problems. Most often in these plants, environmental health hazards are not recognized; when they are recognized, management does not know from whom it can get assistance. In many states management can contact the state health department for competent assistance but this is not so in Illinois.

State Industrial Hygiene Program

In June, 1966, the presidents of the Illinois State Medical Society and of the Chicago Section, American Industrial Hygiene Association, submitted to Governor Kerner a recommendation for executive and legis-

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The articles presented in this section are abstracts of papers presented May 22, 1967, during the Occupational Health Session of the Illinois State Medical Society's annual convention. Dr. Asbury is Medical Director of the Caterpillar Tractor Co.; Miss Brueggen is a writer-lecturer on eye health; Mr. Siedlecki is Assistant Director of the American Medical Association Department of Occupational Health, and Dr. Urse is Superintendent of the Cook County Hospital Mental Health Clinic.

Emotional Problems in Industry

By VLADIMIR G. URSE, M.D./CHICAGO

The urbanization and industrialization of society has tended to create an atmosphere which is less intimate and more impersonal than it once was. In industry the average person spends one-third of his time in contact with his co-workers. Because of the working community in which he spends so much of his time, emotional problems can develop.

The industrial community, and particularly management, is concerned with absenteeism. This is frequently related to low morale in the employee group and may be associated with factors in the working environment. It may also be related to poor motivation on the part of the employee or to an actual depressive reaction in the employee.

Anxiety in employees may be the basis for an increase in accidents or frequent visits to the medical department. Anxiety may arise from problems existing in the home and be carried to work, or it may arise from problems in the interaction of employees.

Over-indulgence in alcohol is becoming more and more of a problem in many areas of our society. It is frequently the basis for absences, especially on weekends or in conjunction with holidays. It requires the utmost diplomacy in handling this problem since most individuals are unwilling to admit their overindulgence.

The need for psychiatric services in an occupational setting is apparent. There are very few full time occupational psychiatrists and most such services are usually on a consultation basis. Referrals should be made through the medical department in order to preserve the doctor-patient relationship. The confidentiality of such a relationship must be preserved and the utmost discretion used in preparing the patient for the referral.

Activities

Health Services for Small Employee Groups

By CHARLES W. ASBURY, M.D./PEORIA

Owners and managers of *smaller* businesses are becoming increasingly aware of the value of industrial preventive health services—and this is simply because a properly organized and functioning preventive medical program in an industry of any size decreases operational costs, increases employee efficiency, and, therefore, company profits.

Those engaged full time in occupational medicine usually function in larger industries—often one which requires a medical staff, or more than one full time physician. The greatest *demand* for services lies in the so-called large industry field, but all physicians who have a full time interest in employee health recognize that the greatest *need* for professional help in occupational medicine lies in the many hundreds of smaller industries, most of which have no organized industrial medical services.

In general, the medical profession is behind in getting employee health services accomplished in the United States. This is partly due to the fact that there is a shortage of physicians who are motivated to do this type of work. And too, often the smaller industries cannot, within their own budget, justify the costs of preventive health services when they attempt to go it alone.

Look at Total Industrial Needs

Our goal is to assist in motivating medical or medically-related people to take a closer look at the total industrial needs of today. Particularly, it is to stimulate physicians in private general practice to orient themselves to this need since they could be the only source of industrial medical help in many communities. Most small-business executives want to satisfy the immediate need to provide prompt and qualified surgical-type care for employees

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Contact Lenses in Industry

By STELLA L. BRUEGGEN, R.N./CHICAGO

Contact lenses, properly prescribed, correctly worn, and judiciously handled, offer visual advantages to many people. Yet, they are not without hazards.

Each year an increasing number of employees are wearing corneal contact lenses. Some are working in areas where lenses are a hazard to eye safety, and, too frequently, without management or the wearers realizing the dangers. An employee wearing corneal contact lenses and concealing this fact during pre-placement health examination can mistakenly be credited with 20/20 vision. A great danger to the eye of such an employee exists:

1. If an injury would be caused by a chemical splashed into the eyes and trapped under the contact lenses, and the irrigating solution would not reach the vital area of the corneas, extensive corneal damage might result before the contact lenses were discovered;
2. If the employee becomes unconscious as the result of an accident and his contact lenses remain on the corneas much longer than his maximum wearing tolerance.

Contact lenses should not be worn in the following work situations:

1. Manufacturing or construction areas, or similar jobs requiring milling, sawing, cutting, or stamping of any solid materials, causing flying particles in the air.
2. Hot molten metals processing.
3. Heat treatment, such as tempering of any metal or other materials.
4. Gas or electric arc welding.
5. Caustic or explosive chemicals or hot liquids or solids handling.
6. An environment containing vapors which act as a solvent for the plastic used to make contact lenses.
7. Repair or servicing of a vehicle.

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Industrial Hygiene

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lative action to institute an industrial hygiene program in the Department of Health in the State of Illinois. The proposal emphasized the need for an adequate occupational health program "to provide services and functions which are not available through private citizens, consultants, or organizations, or which cannot be handled effectively by any group other than a government agency."

A State of Illinois Public Health Study and Survey Commission has recommended transfer of the industrial hygiene activities from the Department of Labor to the Department of Public Health with a suggestion that legislation be formulated for this change with allocation of necessary funds for the proper functioning of the unit. The Commission on State Government also has recommended that the powers of the Department of Labor with regard to the general occupational health program should be transferred to the Department of Public Health.

Urge Support of Legislation

I urge you to favor legislation that will establish an Occupational Health Division within the state of Illinois Department of Public Health and that will allocate funds for the functioning of the unit, by writing to your state representative and senator explaining the need and requesting their full support.

The solution of the small-plant health problem lies in an adequate occupational health program in the state Department of Health, staffed by skilled personnel. Such a program should cover all aspects of occupational health and should include medical, engineering and nursing disciplines. We have seen this activity flourish in this state before the abolishment of the Industrial Hygiene Division in the state Health Department. These services are not now available through the Illinois Labor Department. Without an adequate program our entire community and the economy of our state suffers because of increased loss of time due to illness-absenteeism and in decreases in income and lowered morale.

Health Services

(Continued from page 61)

who are injured—hopefully doing so to return the employee to productive work promptly. Our doctors must satisfy this demand, of course. But society has long since passed through the era of industrial surgery for accidents which have resulted perhaps from poor and unsafe working conditions; a situation where employees have worked on jobs at a risk to themselves and other employees.

An interest should be shown in placing employees on jobs which they can perform most efficiently under the "whole man concept"—and, at this point, we begin to practice *preventive* occupational medicine. The whole man concept is an important starting base for this—and it means, in essence, that an employee's physical, mental, and emotional capacity is determined by a scientific-medical-type investigation. A conclusion is reached after careful study concerning the ability of that employee to function at productive work on a fixed job assignment. However, to accomplish this scientific placement also means that plant doctors must have as much knowledge about the employee's job station and its physical and chemical environment as he knows about the human being he wishes to place in that environment. An unmet need for medically scientific job placement in small industries has existed for many years.

Environmental Medicine

A new concept exists in our society, "environmental medicine." This is concerned with the employee and his family, and their relation to the total environmental problems of day-to-day living—air, water and food—and these inside and outside of the plant need to be in proper balance with all other environmental factors that contribute to a full and meaningful family life. The personnel responsible for health services for smaller industry need to organize and perform health services not just as it relates to the surgical repair of the injured, but to the total concept of community environmental medicine.

In the main, smaller plant operations do not require the services of surgeons for a great volume of injuries. However,

occupational preventive medicine should be practiced in small plants. First, fairly expensive and relatively complete pre-placement examinations—expensive because they include chest and low back X-rays, electrocardiograms for applicants over 40, and audiograms—should be accomplished. The history is taken, and routine physical and laboratory examinations in standard pre-employment examination are also done. All investigations are accomplished primarily to insure “proper job placement, on productive work, in a safe work environment.” Nothing is more important, medically, than to have facts recorded, and available, in a confidential medical record.

Registered Nurse Coverage

Registered nurse coverage on-site, where the nurse performs routine first aid care, also provides nonoccupational therapy to help the employee finish his work shift. In addition, most registered nurses are understanding people who will counsel employees about their health problems—and will handle nonoccupational emergencies just prior to immediate referral for outside medical attention.

The important aspect of a program, I believe, is that the principle of preventive medicine is applied regardless of the size of the plant population—and is applied not only because we are very much interested in the health of our employees, but because we know that this service contributes to employee efficiency, reduces operating costs, and increases profit.

In our ever-changing world, we have moved from the microbiological to a microchemical atmosphere. In this setting, a positive health maintenance program appears to be a requirement for all industries, regardless of size. What our society needs then is an acceptance of this fact, coupled with a supply of physicians and ancillary medical personnel who are interested in solving industry's health problems.

It seems that, as a nation, we have available the tools and knowledge to help solve the health problems originating from the process of man's need to work and provide for his family. Interested and well-motivated professional and semi-professional people are needed to accomplish this task, particularly for small industry employee groups.

Contact Lenses

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8. Critical jobs, such as in the operation of moving vehicles or moving aircraft. The above list is by no means all-inclusive.

It is of utmost importance that employees wearing contact lenses be identified and known to personnel in the employee health service. The following suggestions may be helpful in attaining this objective:

1. Identify applicants who wear contact lenses during the pre-placement health examinations by means of a “light” test, immediately preceding the test for visual acuity. Although corneal contact lenses are invisible, they can be detected by flashing a light into the applicant's eyes from the side, and he is asked, at the same time, to blink. If he is wearing contacts the edges of the lenses will cast circular shadows on the iris which will move as the wearer blinks. In work establishments where pre-placement health examinations are not given, the nurse should give the test to all new employees when the health histories are being taken.
2. Inform employees who start wearing contact lenses after the pre-placement health examination to report this fact.
3. Include the “light” test on all employees during periodic health examinations.
4. Record the fact that an employee is wearing contact lenses on the health record.

Many employees wearing contact lenses believe the lens is an acceptable substitute for safety eye-wear. This is not true. Employees wearing contact lenses should wear the same safety eye-wear that any other employee would wear on a similar job.

Many practitioners in the field of eye health view the corneal contact lens as a non-sterile, and frequently unclean, foreign body. Therefore, poor health practices, such as moistening the lenses in the mouth before inserting them in the eyes, are of great concern. Personnel in the employee health service have a responsibility to teach contact lens wearers the value of good hygiene.

Women in Industry

By A. H. MOVIUS, M.D./CICERO

Let me preface this by saying, "they are here to stay."

First, the career women. There are many more women, highly trained in many varied, technical fields, going into industry as career people. They are competing very favorably for work previously thought of as a man's. Also, their salary structure is rapidly approaching that of their male counterparts.

Experience has shown these women to be extremely well motivated. They display keen interest in their work, originality in their thinking, and productivity. Much of this must be directly attributable to job satisfaction, job interest, and the feeling of being a very active contributing part of management.

These women often put their career on a higher plateau than even their home-life. Because of this they can become quite emotionally involved when there is a stressful situation involving their supervisors or contemporaries. Except for afflictions inherent with the female anatomy, the career women sickness experience parallels that of the male.

Factory Workers

Now, let us discuss the other women in industry, the so-called factory worker or hourly rated female. First, the 18 to 30 age group.

Many in this age group are single or newly married. They need a job for income and have not had the necessary training for so-called office jobs, hence they end up in factory work. Many in this group are not really work motivated but work only for the money. One would anticipate a poor attendance and job performance in this group, as well as a rapid turnover, which is probably one of the most annoying and expensive problems.

Another troublesome facet in the shorter service group (up to 5 years) is that they are not really work oriented. They do not have or have not developed the sense of responsibility of being on the job every day. As an intricate part of an assembly team this works a very definite hardship on production schedules.

Investment in Fringe Benefits

In the 30 to 50 age group we have a group with an investment in the "fringe benefits" of industry today: sickness and accident benefits, insurance paid for wholly or in part, substantially paid vacations, group life insurance plans, and eventual eligibility to pension. One will find many who have found a relatively happy niche in industry, who have made some friends and many acquaintances. They truly enjoy the associations at work.

Other motivating factors are:

1. Accustomed and economically geared to double income.
2. Planning or buying a better home.
3. Planning or actually educating their children.
4. Working just for the better things in life; such as a car, boat, summer home, or travel, to mention a few.

In this group, one would expect to find a relatively stable work population with greater job interest, and on the whole this is true. Strictly from a medical standpoint, we get into the group where frequency rate is fairly constant, but severity rate goes up. Major surgical procedures, such as hysterectomys, mastectomys, cholecystectomys, etc., become more evident.

Menopausal Syndrome

Briefly, I would like to discuss the physiological mechanism of menopause. This, as we all know, is a normal process that all women will go through if they live long enough. When I was in private practice my experience was that I had very little trouble controlling the so-called "menopausal syndrome," and with oral medication, not shots. I can remember no case, except in the few persons who became emotionally disturbed at that time, which I considered disabled by the menopausal syndrome per se. In industry; however, this does not seem to be the fact. We see prolonged periods of disabilities certified to by private physicians with the only diagnosis being menopausal syndrome. Some of these disabilities go on for months. I am quite sure that if this illness were costing employees money through loss of pay, they could and would be back at work.

Let us review the 50 and over age group. Additional security with seniority, plus approaching pension eligibility, acts as a con-

tinuing motivating force. The factors afore mentioned have been satisfied or are less pressing. However, many in this age group are just tired of the daily routine of going to work and would like to start enjoying some of the lighter social aspects of living. Thus, as we would expect, we find attendance becoming spotty and with it efficiencies tend to decline. There is, however, a noticeable difference in the married women when compared to the widows or spinsters who are compelled to be self-sustaining, and their associations on the job are still very important to them.

In this group, medically speaking, we begin to see the toll of degenerative diseases. Cardiovascular with hypertension is a major problem which in itself is responsible for repeated and prolonged periods of disability. Arthritis, a perennial problem in this age, is often responsible for very prolonged and recurrent periods of disability, and necessitates work restrictions which often call for a change in job assignments. Alcoholism in the female, although not as prevalent as in the male worker, is quite a problem when it does exist.

Civil Rights Act

In summary I would like to cite a recent communication.

"The provisions regarding discrimination on the basis of sex in Title VII of the Civil Rights Act of 1964 has caused industry to alter some long standing views and practices for those who have held deep convictions supporting the former practice; the necessary change in attitude and performance has not been easy."

"A recent arbitration ruling in this area is of interest and serves to illustrate what we consider to be the necessary approach in these cases. Briefly stated, a paper company had taken the attitude that specific jobs which were indeed quite demanding physically were not suitable for women. Five senior female employees laid off because of their lack of qualifications for these jobs filed a grievance."

"The arbitrator stated that, 'Some aspects of these jobs are beyond the physical ability of many women and require a degree of muscular strength not normally possessed by women.' But he went on to indicate that some women exceed some men in physical and muscular attributes and 'the company has closed the jobs in question to females as a class, which it cannot do under the company's anti-discrimination clause.' Grievance on behalf of the five women was upheld, but the arbitrator summed up by stating that some women are stronger than some men, although females as a group do not possess the strength and vigor of males and require greater protection against industrial risks and hazards than do males. Hence, an employer has the right to condition the assignment of females to hitherto all male jobs upon their passing of a medical or other examination. They cannot arbitrarily hold them disqualified because they are women. This must relate to the individual employee."

This all means that all of us had better start thinking in terms of physical requirements and types of examinations we are going to require before we assign women to heavy physical work previously done by men.

WHAT IS A PHYSICIAN?

Of the qualities of a physician which we should all keep in mind, I believe integrity comes first. In a scientist, intellectual honor, in a physician, simple devotion to the truth that goes beyond merely thinking of it in austere and mechanical terms take on a spiritual grace as they become integral with the character of the person who has them. Without integrity patients would be at the mercy of any man who wished to exploit the great confidence patients have in physicians. Happily, this is rarely exploited. But physicians are people, and people are not always as good as they should be. After integrity, another quality—I do not give these in any special order—is knowledge. He must have a comprehension of the fields of endeavor in medicine as he has undertaken to practice, teach or investigate. Group Practice, May 1966.



OFFICE HOURS BY APPOINTMENT

British general practitioners are discovering that the appointment system is effective, even though they may spend less than five minutes with some patients. According to Cardew:^{1,2} "An appointment system has completely altered our lives; it has brought order out of chaos and we can never cease to wonder how we endured our old ways so long." He estimates that 17,000,000 people can now consult their physician by appointment. An English survey showed that the vast majority of physicians had no trouble introducing the system into their practices and were satisfied with the way it worked. The elderly and persons of low intelligence found the appointment system difficult at first, but once they got used to it, they liked it. The average Britisher halved the time he spent in the reception (not waiting) room. In addition, having an appointment gave status to the consultation. Punctuality was the rule. Ten percent were tardy, but of these, only a third were more than five minutes late.

Carne³ of London also found the system workable even though his practice included a high proportion of West Indian and

West African immigrants. These people are notoriously poor timekeepers. Carne is a general practitioner in group practice. His group switched to the appointment system because of a shortage of space in the waiting rooms. The three physicians have a list of 1,600 patients and had to restrict the number of people waiting to be seen at any one time. Since starting the appointment system, their waiting room, that seats 12, is rarely full to capacity. Each doctor sees up to 12 patients an hour. Of all patients seen by appointment, 13.8 percent walked right in on arrival; their doctor was waiting for them. Carne and his colleagues rely very heavily on their three receptionists for the success of the appointment system.

T. R. VAN DELLEN, M.D.

1. An Appointment System Service for General Practitioners: Its Growth and Present Usage. Bruce Cardew. *Brit. M. J.* (Dec. 2) 1967.
2. Appointment Systems in General Practice. Leading Articles. *Brit. M. J.* *ibidem*.
3. An Appointment System in a Practice with Immigrant Patients. Stuart Carne. *Brit. M. J.* (Dec. 2) 1967.

Grievance Committee, Public Relations, Medicare and the Prevailing Fee

By TED LeBOY, M.D. / RIVER FOREST

For many years the medical profession through county societies has fostered a prime public relations mechanism, the Grievance Committee. The Grievance Committee has performed remarkably in permitting the public to air complaints against member physicians. Many of the complaints, as the records show, are unjustified, some represent misunderstandings and some, indeed, are justified. Due to the tact and skill with which grievances are handled, the medical profession is generally able to explain away hostility constructively. It gains prestige when such a complaint is satisfactorily answered. Bonafide complaints receive meticulous handling and the patients' interests are served in an unprejudiced manner.

The members of the medical profession who serve on Grievance Committees have attempted, on the basis of their knowledge of local fees, to control excessive medical costs for the public. In the adjudication of a complaint against a member physician of excess charges, various elements of the patient's stature in the community are considered. For example, the income of the individual making the complaint is important and the number in the family is a consideration. The type of surgical or medical procedure involved is evaluated. Occasionally, personal confrontation between the

complainant and the physician has been arranged. A final decision as to the merits of the complaint is reached and when indicated appropriate financial adjustments are recommended.

Usual and Customary Fees

All of this concerns itself with the usual fee for the physicians and customary fee for the area, and in fee disputes, it is on these bases that adjudication is made.

Medicare posed a great number of problems and it was certainly not unexpected that the Grievance Committee would sooner or later be called on to resolve some of these difficulties. Soon after the implementation of this law a new problem evolved. "Usual and customary fee" as defined by the Department of H.E.W. is not the customary fee in the area, but it is the usual and customary fee peculiar to the physician himself. The Medicare program provides for a prevailing fee which is an upper limit of payment. Furthermore, under Public Law 89-97 the factors of income and other non-medical facets are not to be used in determining the charge for medical service. The usual and customary fee is the doctor's usual charge, his customary charge, and the prevailing fee is a special average fee calculated on an area-wide basis. Payment for usual medical services will not exceed the



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prevailing fee. It is the responsibility of the carrier under Part B of Title XVIII to determine the reasonable fee by various methods, and to resolve problems of fee determination for services to the beneficiary. The carrier may call on the medical society for advice, if it wishes. In any event, the determination of usual and customary fees for different persons and under different standards causes confusion.

Different Definitions

When a physician answers a Grievance Committee's query as to the amount charged, he replies, "this is my usual and customary fee". It is difficult to argue that the fee, if it is established by the physician as his usual and customary, is excessive. However, when a beneficiary of Medicare, who is enrolled in the supplementary medical insurance program, complains to the Grievance Committee that the physician charged an excessive fee, a different definition of "usual and customary" may be required. This is most likely to occur on direct billing when the carrier does not allow the full charge and then pays only 80 percent of the revised amount.

The Grievance Committee, proceeding in its usual manner, would take this complaint for investigation. We will assume that the fee was \$500. The Grievance Committee, after reviewing all of the pertinent facts, might decide that a fee of \$350 was fair and proper for the services rendered. However, if the complainant was a Medicare beneficiary who had submitted the original amount to the Medicare carrier, it is possible the Medicare carrier, on the basis of its determination, might decide that an allowable fee would be \$275. One can readily see the dilemma that not only the beneficiary is placed in, but also the Medical Society, the physician, and the Social Security Administration. If one likes double standards, this is a case at point. We can also reverse the situation. We can say that the Medical Society approved a smaller fee than the Social Security Administration's carrier. We can assume that the carrier has acted on information in its possession and in accord with the established Medicare procedures. The final result is the same—confusion.

Cooperation with Carrier

A physician, particularly one on a Grievance Committee and one in the Medical

Department of the Medicare carrier, could very easily justify the decision to their respective administrations. It is very difficult, however, to equate the two sums to a beneficiary who may have difficulty in understanding even the simplest type of explanation.

It is time for the Grievance Committees in the various counties over these United States to align their sights to a problem such as this. Its appearance will be expected to occur with increasing frequency as the Medicare Program continues. The question of whether or not liaison can be established with the carrier for the particular locale is something that must be determined with the particular carrier on an individual basis. It is logical and timely to assume that the carriers need all the help that they can get so as to determine the reasonableness of the payments made to the beneficiaries or the assignees. Cooperation with the Medicare carrier is essential. The physician's public relations which have been so well performed by the Grievance Committee will still occupy one of the sparkling niches in the public thought if a solution for the problem is obtained. The wisdom of the carriers' performance in the Medicare operation will also be enhanced.

The Bureau of Health Insurance of H.E.W. has suggested that any Grievance Committee problems of this type be submitted to the carrier for consideration. This unfortunately is cooperation on a one sided basis because of necessity of the carriers' performance under the Medicare act regulations. While this still may be the proper handling needed to insure consistency in fee determinations at the present time, complete cooperation for the benefit of the patient, the carrier, the physician and the profession is needed. Liaison is essential. Formalized procedures and adequate record keeping by Grievance Committees cannot be postponed. Either medicine will assume leadership based on a sound record or medicine will suffer a loss of this responsibility by default.

* * * * *

Alaska has the nation's largest land area, 586,400 square miles, and the smallest population of all 50 states, 267,000. More than one-tenth of its population, 27,000, are veterans, according to the Veterans Administration.

Professional Courtesy: Where Do You Draw the Line?

Should the time-honored custom of professional courtesy be extended without limits to all physicians and their immediate families, or should its application vary according to circumstances?

What about the psychiatrist, for example? Should he render his services without any fee whatsoever when long-range care involving one or two hours weekly of his restricted patient load is involved?

What about the obstetrician in the college town who has the wives of all medical students—a significant percentage of his practice—as his patients?

What about the ophthalmologist who is called upon to fit contact lenses for members of a physician's entire family?

If no fee would have been charged, had the patient been without medical-hospitalization insurance, would it be considered proper to accept insurance payments for the professional services provided?

Because of the increasing specialization in medicine and continuing changes in medical practice, the AMA's Judicial Council has been swamped with requests to clarify its position on professional courtesy.

To provide physicians with guidance on the matter of professional courtesy, the Judicial Council adopted the following opinion:

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.
2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.
3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.
4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.

* * *

A few copies of "Supply, Demand and Human Life," a six-page, color pamphlet describing the increasing importance of blood banks and the significant role fulfilled by voluntary blood donors would be a worthwhile addition to your supply of reception room literature.

Complimentary copies are available from AMA's Department of Environmental Health, 535 N. Dearborn St., Chicago 60610. The pamphlet points out that the annual blood requirements of the nation currently are being provided by only three percent of the eligible donor population.

* * *

The third revision of *Group Practice: Guidelines to Forming or Joining a Medical Group*, originally published in 1962, is now off the presses. Medical societies and individual physicians may obtain complimentary copies by writing the Department of Health Care Services, American Medical Association.

Jointly produced by the AMA, the American Association of Medical Clinics and the Medical Group Management Association, the 40-page booklet covers all aspects of group practice.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

SIU Proposes New Medical Education Plan for Illinois

Southern Illinois University proposed a medical education plan for Illinois which it said "would most efficiently and least expensively meet the demand for professional manpower that is especially urgent in the field of health personnel." The plan—authored by SIU vice president Robert MacVicar—offers: a shortened but comprehensive M.D. degree program; a medical school that would be an interlocking system composed of existing universities and hospitals; and a separate but coordinated medical research unit and computerized information network. The plan calls for training of "para-professional medical aides" who would fill what SIU termed "the gap between the increasingly rare general practitioner and the super-specialists." The aides, MacVicar said, would function in the civilian setting "as non-commissioned officers have functioned for many years in the armed services." Their main service—emergency treatment and diagnostic care—would be to patients in small towns or those "unable to afford service at office-call prices." MacVicar also proposed establishment of an Illinois Institute of Health which would operate its own research laboratories and hospital. It would also coordinate research at regional medical centers.

* * *

Court Rules New Service Occupation Tax Unconstitutional

The Illinois Supreme Court this month will hear an appeal from a Circuit Court ruling that the new state service occupation tax law is unconstitutional. The law is the same one which Dr. Paul Sunderland of Gibson City and ISMS challenged shortly after the State Revenue Department ruled that physicians had to pay the tax on drugs and medicine which they dispense. Dr. Sunderland won a temporary injunction restraining the Revenue Department from collecting the tax from doctors. The entire law was ruled unconstitutional in December by Cook County Circuit Court Judge Thomas C. Donovan.

* * *

Trial Lawyers Hear Panel Discussion on Malpractice

Several hundred members of the Illinois Trial Lawyers Association meeting in Chicago heard these comments from participants in a panel on medical malpractice: Louis G. Davidson, Chicago, chairman of the Illinois Supreme Court Committee on Jury Instructions said, "We (trial lawyers) are a cause of great anxiety among physicians. It's disturbing that malpractice actions have to be brought. Physicians have been able to go on their way in some instances committing horrendous assaults upon their patients without recompense to the patient. We must have some means of keeping pressure on the doctors to do a better job." James

A. Dooley, Chicago, past president of the International Academy of Trial Lawyers, advised that the answer to "Who to sue?" in a malpractice case is "Everybody—sue anyone who had anything to do with the case. Don't be misled by the doctor who tells you that he will help you in your case against a hospital. Make the doctor a part of the suit." J. B. Spence, a Miami attorney who won a \$1-1/2 million judgment in a malpractice suit, outlined how he builds his case against a doctor. First, he makes a thorough study of the physician and hospital records, plus the medical reports of other doctors who treated the patient. Then he determines what literature the accused doctor has in his library on the medical entity involved in the suit, because the attorney is "going for the standard of care as outlined in these textbooks." Spence's preparation also includes a credit report on the physician and a check of court house records to determine whether the doctor has been involved in other legal proceedings. Finally, Spence checks newspaper morgues for news clippings on the doctor's past.

* * *

New Tax Rules Hit Illinois Medical Journal

Net advertising profits of the *Illinois Medical Journal* will be taxed under regulations issued in December by the Internal Revenue Service. A 48 percent federal corporate income tax will be levied against the advertising revenue over and above that needed to operate the publications of non-profit associations such as ISMS, the American Medical Association, labor unions and educational groups. The IRS regulation likely will be fought in Congress and the courts.

* * *

Public Aid Department Paying for Examinations of Indigent Children

The Illinois Department of Public Aid is now paying for school physical and dental examinations and immunizations for indigent children. Payment is made, however, only if the services are not available without charge in the community. Harold O. Swank, IDPA director, said his department will pay the established charge for indigent children who are given exams or immunizations through organized community programs sponsored by local health units, school districts or county medical societies if IDPA has approved the plan.

Medical School Applicants (Continued from page 13)

A number of factors serve to limit the selectivity of both medical schools and applicants. There is an overlap in the ability levels of accepted and rejected applicants. Mean scores indicate improved performances over previous years, which suggests that an increasing number of rejected applicants might have qualified for admission if additional places had been available. This consideration, together with projected increases in the number of ap-

plicants, indicate a potential for significant expansion of medical school enrollment without compromising high admission standards.

Among nearly 26 million U. S. veterans are 15,000 post-Korean veterans under 20 years of age and 9,000 Spanish-American War veterans 89 years of age and older, according to the Veterans Administration.



Indications: Tofr nil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of Tofr nil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofr nil may be substituted. Initial Tofr nil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the

possible risks, Tofr nil should not be used during the first trimester of pregnancy.

Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofr nil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.

Because of its anticholinergic effect, caution should be observed in prescribing Tofr nil for patients with increased intraocular pressure.

In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofr nil was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.

The drug is not recommended at present time in patients under 12 years of age.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including

With the patient often alone, overly concerned and worried during convalescence, anxiety can swell to excessive proportions, filling the long hours and jeopardizing the benefits of strict and necessary bed rest—despite reassurance.

The immediate crises of his coronary crossed, the patient, of necessity, must submit to a regimen of strict bed rest that allows him little to do but wait—ad wonder. Even when the prognosis is favorable, he worries about the future—his health, his livelihood, his family—and his worries can assume alarming proportions, eroding the benefits of his enforced inactivity and of the physician's reassurance. Alone, apprehensive, the patient becomes increasingly uneasy and his anxieties intensify, often to the point of impairing convalescence.

The adjunctive use of Librium (chlordiazepoxide HCl) can help the patient during this "anxious interval." The drug usually acts quickly, helps to pay undue anxiety posed by the real and imagined threats that often accompany serious illness and relieves the patient of the added burden of these threats. The reliable antianxiety action of Librium (chlordiazepoxide HCl) can reinforce the physician's reassurance and promote an emotional climate beneficial to the patient. Librium (chlordiazepoxide HCl) *h.s.*, added to the regular t.i.d. schedule, also can help relax the patient at night, encouraging the restful sleep that comes from relief of anxiety.

After seven years' use, Librium (chlordiazepoxide HCl) continues to demonstrate an impressive record of safety. When they do occur, side effects, such as drowsiness and ataxia, in most instances are mild in degree and usually reversible with reduction of dosage.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as

MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Laboratories
Division of
Hoffmann-La Roche Inc.
Nutley, N.J. 07110

during the anxious interval

Librium® Roche®

(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules

Also available as **Libritabs™** (chlordiazepoxide)
5-mg, 10-mg, 25-mg tablets



AAP Announces Head Start Medical Consultation Program

A new partnership between Project Head Start and the pediatricians of America has been announced by the Office of Economic Opportunity and the American Academy of Pediatrics.

Sargent Shriver, director of OEO, and William S. Anderson, M.D., F.A.A.P., president of the AAP, in a joint statement, said that the Academy will organize and direct the Medical Consultation Program of Head Start child development programs in nearly 2,000 communities throughout the United States.

The Academy has chosen Robert S. Mendelsohn, M.D., F.A.A.P., a pediatrician from Chicago, and formerly medical director, Project Head Start, Cook County Office of Economic Opportunity, to direct the program.

Mr. Shriver welcomed the wholehearted support offered to the program by the Academy which represents more than 10,000 pediatricians in the U.S., Canada, and Latin America. The AAP, to a large extent, has set the standards for child health care both in this country and abroad.

Mr. Shriver stressed that this contract represents a new type of relationship between an agency of the Federal Government and a voluntary professional organization. In effect, the American Academy of Pediatrics has accepted a major responsibility for ensuring that the health services provided to Head Start children adequately meet the health needs of these children, their families, and the community in which they live.

Dr. Anderson said that initially, the AAP will select about 300 physician consultants from its membership and from other leaders in the field of child health, to evaluate the medical aspects of the Head Start program at the state and local level. He emphasized that as more physicians gain experience in working in community health programs, their increased skills and knowledge will make their advice more valuable in planning and carrying out those programs which require partnership between physicians and government.

Each medical consultant selected will work with the medical director and other health professionals in Head Start projects.

He will review the medical aspects of Head Start applications submitted by a

community; meet with local planning committees to map out Head Start medical programs; maintain contact with program medical directors; follow up and evaluate programs, and maintain liaison with OEO regional and national offices.

Consultants will work with the Office of Economic Opportunity representatives responsible for funding and evaluating Head Start health programs, helping them interpret the needs of the children, the resources of the community, and the success of the Head Start programs. The consultant will supplement, rather than replace, the medical and administrative skills available in each community.

Further commenting on the program, Dr. Anderson pointed out that "the Academy executive board and staff are enthusiastic about the opportunity this program offers for developing responsible pediatric leadership in an important area of child health programming."

"I believe this is an activity which will most certainly expand," Dr. Anderson emphasized, "and could set an important trend in the programs of medical organizations."

He further indicated that the AAP's broad experience and capacity for developing comprehensive child health programs, will enable the Academy to provide medical supervision which will ensure excellence and quality in the health services provided under Head Start programs.

* * *

Accidental Poisoning of Children

Accidental poisoning of children 12 years of age and younger is a serious problem. Recent statistics released by the Illinois Department of Public Health reflected a total of 11,961 such cases in the state for the first few months of 1967. Of these 3,888 occurred in Chicago. Children under four have the greatest incidence, there being 3,242 cases of one-year olds, 4,339 cases of two-year olds and 2,480 cases of three-year olds. The biggest offender is internal medication, 7,215 cases, of which 4,535 were aspirin ingestion. Household preparations accounted for 1,466 while pesticides and paints and varnishes counted over 500 victims. The rate of occurrence of these accidental poisonings is slightly higher during the winter months.

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly peri-arterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

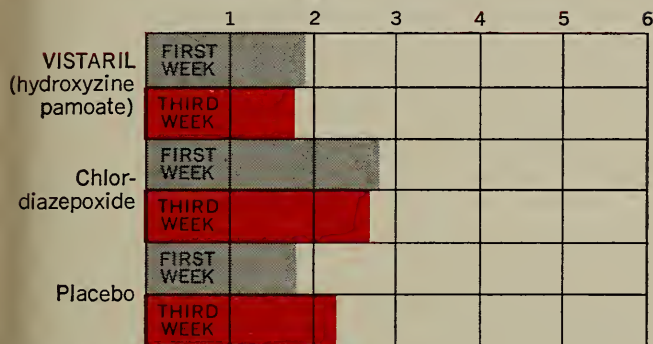
Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

Increase in hostility minimized with Vistaril and chlordiazepoxide

Composite Rating of Hostility:

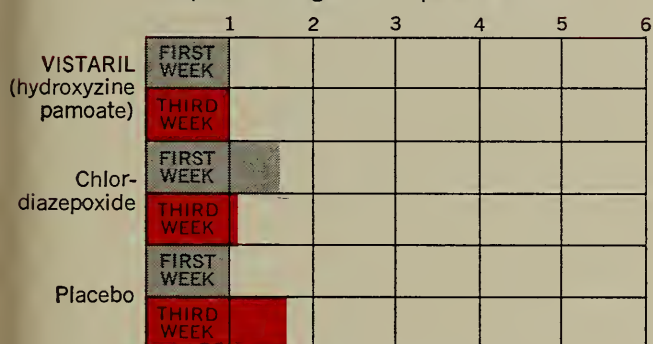


OVERALL CHANGE IN HOSTILITY (%)

VISTARIL (hydroxyzine pamoate) 5% Chlor-diazepoxide 4% Placebo —28%

Cooperativeness not a significant problem

Composite Rating of Uncooperativeness:



OVERALL CHANGES IN COOPERATIVENESS (%)

VISTARIL (hydroxyzine pamoate) No change Chlor-diazepoxide 31% Placebo —70%

In Alcoholism...

Vistaril®

(HYDROXYZINE PAMOATE)



LABORATORIES DIVISION
New York, N.Y. 10017

Looking for A Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the Journal is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

ADAMS COUNTY: Golden; population 491. Trade area: 2500. Nearest physician 9 miles. Nearest hospital at Quincy, 32 miles. Financial assistance available. Many residents of German descent. Agricultural community. 3 Lutheran, 1 Methodist churches. 45 bed nursing home full. Last physician, now deceased, practiced here for 56 years; lucrative practice. Nearest golf course, 14 miles. For details contact: Myra W. Bennett, Adm., Golden Good Shepherd Home, Golden, phone: 696-4421, Rev. E. A. Slotag, Golden, phone 696-2343, or Frank Adrain, M.D., Clayton, Illinois; phone TW 4-6409.

ADAMS COUNTY: Liberty; population 325. Only physician died August 1958; replacement needed. Nearest physician at Clayton, 17 miles, and Quincy, 20 miles. Housing available. No information re available office space furnished. Agricultural community. Churches: Lutheran, Christian, United Brethren and Catholic. Grade and high schools. Nearest hospitals at Quincy: St. Mary's and Blessing, 400 beds; citizenship required for staff membership. For further information contact: Raymond Longlett, Liberty, F. Wayne Baughman, Adams Co. Farm Bureau, 121 N. 7th, Quincy or E. N. DuPuy, M.D. 1011 Maine Street, Quincy, Illinois.

ADAMS COUNTY: Mendon: population 800. Population of Ursa, 4 miles: 400. Trade area: 2500. Only physician died re-

cently after practicing here for 20 years. Nearest physicians and hospitals at Quincy, 15 miles. Community willing to erect a medical facility. Agricultural community. 6 protestant and catholic churches. Grade and high schools. 2 hospitals at Quincy; 500 beds. For further details contact Mr. Harold Mealiff, Chairman of Lions' Club committee to find a physician, Mendon, Illinois.

ALEXANDER COUNTY: Cairo. Population: 9500. Trade area: 30,000. 7 physicians, ages 61, 60, 80+, 75, 60, 45, 50. St. Mary's Hospital; 125 beds. Open staff. 150 miles from St. Louis. 5 prescription stores. Offices available in new medical arts bldg. to be constructed. Up-to-date equipment of a physician available if desired. Financial assistance if desired. Agriculture & industry. 18 Protestant & Catholic churches. Grade & high schools. 2 Country Clubs with club house, pool, lake & golf course. Excellent hunting & fishing. For details contact: Charles Yarbrough, M.D., 800 1/2 Commercial Avenue, Cairo. Phone: 157. Sister M. Clarissa, St. Mary's Hospital, Cairo. (Administrator)

BOND COUNTY: Sorento: population: 800. Trade area—2500. Only Dr. moved due to illness. Nearest Dr. at Greenville, 15 miles. Greenville hospital has 70 beds. 50 miles from St. Louis, Mo. Attractive house with office in front available if desired. Financial assistance if desired. 5 Protestant churches. Nearest Catholic church, 4 miles. Grade school. Bus to high school. Country Clubs with golf courses at nearby Greenville & Hillsboro. For further information contact: Mr. Arthur Perfetti, Funeral Director, Sorento, Illinois, Phone 69.

BOONE COUNTY: Belvidere, population: 12,000. Trade area: 25,000. Rapid growth in population due to opening of new Chrysler Plant. Population will soon reach 30,000 due to new recruitment program. 10 general practitioners. More needed. Medical society anxious for general practitioners or internists to locate here. Two hospitals: 100 and 75 beds. 15 miles from Rockford, population 125,000. Several prescription drug stores. Office space available. Agricultural and industrial area. 14 Protestant and Catholic

churches. Public & parochial schools. Country club with golf course. On Northwest Tollway, 75 miles from Chicago. Contact: Earl Davis, M.D., Belvidere, Ill.

BUREAU COUNTY: Neponset. Population: 520. Town without a physician since 1963. Nearest physicians at Kewanee, Sheffield and Princeton, 8, 6, and 20 miles. Nearest hospitals at Kewanee, 8 miles. 50 miles from Peoria. Local Chamber of Commerce will arrange for financial assistance. Agricultural community. Congregational & Methodist churches. Grade and high schools. Nearest country clubs at Kewanee & Sheffield. Former physician, who moved to return to his home town, enjoyed a large practice. Office space available. Houses & apartments for rent. For further information contact: Mr. Howard Bremer, 104 S. Second, Neponset, phone 3422 or Mr. Edwin Peterson, Martin Engineering, Neponset.

BUREAU COUNTY: Princeton: population: 6200. Trade area: 40,000. 11 physicians. 95 bed hospital. 60 miles from Peoria. 3 local prescription drug stores. Office bldg. of deceased physician available if desired. Predominant nationality: Swedish. Agriculture and industry. 10 Protestant & Catholic churches. Grade & high schools. Facilities for golf, tennis, swimming, hunting, community concert series. County seat. 115 miles from Chicago. Contact: W. E. Erkonen, M.D., 726 S. Main, Princeton, Phone 28111, or Administrator, Perry Hospital, Mr. C. J. Riley, or Mrs. Wilda T. Makutchan, Princeton, Illinois.

Following additional towns in Bureau County are also reported to be in need of additional general practitioners: Sheffield, Neponset, and Spring Valley. For detailed information contact Donald Funk, M.D., Walnut, Illinois.

THE PROBLEMS EXEMPLIFIED

Certain repetitive scenes go on day after day in the emergency room. A patient on public assistance, rushed to the hospital in a city ambulance, is discovered to have a cold or gastroenteritis. The harried interns in the "pit," having established the diagnosis, react with resentment and frustration: "Why'd you take the ambulance? That costs the city \$50. Why don't you take the bus?" The patient becomes defensive. The intern's ultimate argument follows: "The city has only a few ambulances. While you were coming to the hospital, your ambulance was tied up, and somebody with a heart attack might have died! Just because you abuse the service."

The argument seldom has an effect. Like the neurotic, unchanted by the observation that his fears are foolish, the ambulance rider does not seem to be worried by the specter of the other man who is dying in the street.

Similarly, in the clinic, the same faces appear over and over with the same constellation of chronic "real" and "functional" complaints. The physician is frustrated by both. The problems of the chronically ill have received scant attention until recently, and it is difficult to maintain such patients in the outpatient department month after month without a unified program. And treating patients with no "real disease" is even more frustrating to the busy house officer. "Perhaps," he may muse, "it would be better to discourage these patients from the clinics in the first place."

The outpatient-physician relation creates pressures on both sides. It is an odd relation; often, the patient-hospital relation is more lasting and deeper. After all, in most clinics the physician continually changes whereas the patient and the hospital endure. The role of the house officer is, in addition, necessarily ambiguous. He is at once the implement of the city in meeting its medical responsibilities and a young physician in training at a teaching institution, eager to learn his profession. The New England Journal of Medicine, June 30, 1966.

When the emotionally impaired patient pays an office call...

She asks for your help, but just can't seem to follow through on your advice.

When not at your office, she's constantly on the phone: can't sleep, headaches, G.I. upset.

She's excessively apprehensive; demands much more of your nurse's attention.

for moderate to severe anxiety
Mellaril[®]
(thioridazine)
25 mg. t.i.d.



She often seeks a physical explanation for her distressing emotional state.





See following page
for additional product information.

When the emotionally impaired patient pays an office call...

Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as moderate to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety
Mellaril[®]
(thioridazine)
25 mg. t.i.d.



President's Message

(Continued from page 10)

no help to perform society business, but each member of his group bears a certain amount of responsibility to keep himself informed. Every May, when the House of Delegates meets, we are startled to hear someone jump up in righteous indignation to complain about something we have been trying to explain to him for months.

If it isn't too late for New Year's resolutions, I'd like to suggest this one: To be more interested in the affairs of organized medicine by insisting that my county medical society be active, alert, and informed. Communication is a two-way street.

Planning to be in Chicago in the foreseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 N. Dearborn St., just north of the Loop, anytime during office hours—8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

NOTICE OF RATE INCREASE

Due to increased costs in production and distribution it has been necessary to raise the rates on classified advertisements, effective Jan. 1, 1968. Standing orders will be honored at the old rates for the duration of their present order.

Effective Jan. 1, the rates will be:

	Insertions			
	one	three	six	twelve
30 words or less	\$5	\$12	\$18	\$30
30-50 words	\$8	\$14	\$24	\$40



Photo professionally posed.

No injection after all! This penicillin produces high, fast levels—orally.

Pen·Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN·VEE® K**
(potassium phenoxymethyl penicillin) 

New Films & Film Guide

A new film guide, "Selected Mental Health Films," is available from the National Institute of Mental Health. Emphasis is on the progressive new approach to mental health, centered in the nation's communities, in a wide range of subjects such as marriage and family life, child development, crime, aging, etc.

Highlights of each film are described, together with suggestions for suitable audiences. Guidelines for discussion groups, suggestions for effective use, plus film resources, both free and rental, contribute to the usefulness of the guide. It is available from the Department of H.E.W., Public Health Services, N.I.M.H., Chevy Chase, Md. 20203.

* * *

Prescription for Life is an intense, 50-minute, 16mm full-color training film which uses vivid academic portrayals and dramatic medical re-enactments to emphasize the important details of all aspects of emergency resuscitation. The film has been acclaimed as one of the foremost in its field and will be translated into several languages for world use by members of the International Medical Profession. Released only to hospitals and medical schools, this film may be obtained from Bandelier Films, Albuquerque, N.M.

Another new release, geared primarily for hospital technologists, is entitled *Method for Rapid Electrophoresis*. It is a 16mm, color sound movie, running 11½ minutes, to help train technologists in the use of electrophoretic equipment for rapid analysis of serum and other body fluids. Produced by the PHS Audiovisual Facility in collaboration with St. Joseph's Infirmary, Atlanta, Ga., the film is available on short-term loan from the Distribution Unit, PHS Audiovisual Facility, Atlanta, Ga. 30333. Or it may be purchased from DuArt Film Laboratories, Inc., 245 West 55th Street, New York, N.Y. 10019.

* * *

Parent to Child About Sex, a new film produced by Dr. Frederick J. Margolis, director of the medical audio-visual unit at Wayne State University School of Medicine, is designed to help parents and adults in sex education in the home. The film

has been approved by the Health Education Department of the AMA and has been recommended for showing by the National Council of Churches. Suggested audiences are parents, high school and college students, church groups, YM and YWCA groups, service clubs, teachers education courses and physician and nurse training classes.

The film may be obtained for showing from Wayne State University School of Medicine, Audio-Visual Utilization Center, Detroit, Mich. 48202.

* * *

To Face Life Again is the title of a 16mm, black and white sound picture running 28 minutes. It is subtitled "Rehabilitation Through Reconstructive Plastic Surgery" and was produced for the Public Health Service by the Society for the Rehabilitation of the Facially Disfigured, Inc. The intended audience is nurses, nursing assistants, medical social workers, counselors, physiatrists, and therapists. It demonstrates various types of disfigurement, describes the basic problem and shows in interviews the adjustments of patients to their conditions. Free short-term loan is available from the PHS Audiovisual Facility, Distribution Unit, Atlanta, Ga. 30333, or it may be purchased from DuArt Film Laboratories, Inc., 245 West 55th Street, New York, N.Y. 10019.

* * *

"Jerry" is the title of the first training film ever produced about the modern rehabilitation of asthma patients. Made by the National Jewish Hospital at Denver under a grant from the Rehabilitation Services Administration of the U.S. Dept. of Health, Education and Welfare, the film centers on the rehabilitation of asthmatic victims. All the patients seen in the film, produced by Spencer Nelson Productions, Boulder, Colo., are chronically ill asthmatics who had not responded to treatment prior to being admitted to National Jewish Hospital. Physical therapy techniques, exercise programs, vocational counseling, and a sheltered workshop program all are depicted with a view to helping others set up similar programs.



help tip the scales
for your
“should-but-can’t”
dieters...

- ☐ controls the appetite
- ☐ provides gentle ‘lift’ to strengthen patients’ determination to stick to dietary instructions
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Each AMODEX TIMED CAPSULE contains:

dextro-amphetamine HCl	15 mg.
amobarbital (barbituric acid derivative)	60 mg.

WARNING: may be habit forming

DOSAGE: One capsule on arising or at breakfast. Drugs are released gradually over 6 to 8 hours, providing therapeutic effect for 10 to 12 hours.

INDICATIONS: AMODEX Timed Capsules elevate the mood, relieve nervous tension, restore emotional stability and emotional capacity for physical and mental effort. AMODEX Timed Capsules are extremely useful in the treatment of anxiety states and may be used to control appetite in the management of the obese patient — without nervous excitation.

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CONTRAINDICATIONS: Hyperexcitability, agitated pre-psychotic states. Sensitivity to Amphetamines or Barbiturates.

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Detroit, Michigan

Patient Referrals—To Clergymen

BY PASTOR MALCOLM B. BALLINGER/WILKINSON, IND.

(Pastor Ballinger is the former chaplain and director of clinical pastoral training at the University of Michigan Medical Center, Ann Arbor. This article is reprinted from his manual, "Religious Care for Hospital Patients." He is now pastor of the Methodist Church in Wilkinson, Ind.)

Chaplains are interested in seeing all patients of their particular faith. Time, however, does not usually permit coverage of all patients on all the hospital wards. Chaplains appreciate doctors and nurses calling their attention to those patients who are in particular spiritual need. The following situations indicate a need for a chaplain:

Patients who express religious interest or need.

Sometimes patients openly and specifically ask for a chaplain or clergyman. Some may ask for Bibles, prayer books, devotional literature, Rosaries or Phylacteries. Expressions of concern over inability to eat certain kinds of foods for religious reasons, or to receive medications, or to be seen by a psychiatrist, indicate possible need of council by a chaplain. When a patient receives news of death in his family, a chaplain should be called to help in the bereavement situation.

Patients who express exaggerated fear, anxiety, guilt or excitement.

A patient may be exceedingly fearful, full of overanxiety, have feelings of guilt over his illness, or be excited about his illness out of proportion to the reality situation because he fears punishment from God. The chaplain or clergyman is best able to size up the situation and handle feelings of the patient meaningfully and constructively.

Patients who are severely depressed, who have attempted suicide, who express a desire to die.

These are situations in which the patient obviously needs spiritual assistance beyond that which can be given by the doctor or

nurse. Instead of merely sedating the patient, or scolding or trying to pep up the patient, the chaplain or clergyman should be contacted and be given as much information about the situation as possible so that he can cooperate with the medical and nursing care to be given.

Non-cooperation, belligerence, non-acceptance of the diagnosis.

These attitudes are nearly always symptoms of deeper underlying distress. The doctor or nurse is likely to react unkindly against such patients, when they are in serious need of spiritual help. The chaplain can seek for the reasons for such attitudes and assist patients to recover a more rational behavior.

Facing serious surgery, handicap, deformity.

If the patient is facing serious surgery which may threaten his life, then the chaplain should be informed in case there are certain religious obligations which need to be fulfilled. Acceptance of and adjustment to some physical handicap or deformity is always a very difficult emotional problem requiring the utmost assistance and support of all.

There may be religious restrictions or taboos to certain recommended medical or surgical procedures which should be discussed. It has been demonstrated that the patient that is spiritually prepared makes a better adjustment and has a smoother recovery than the patient who is not.

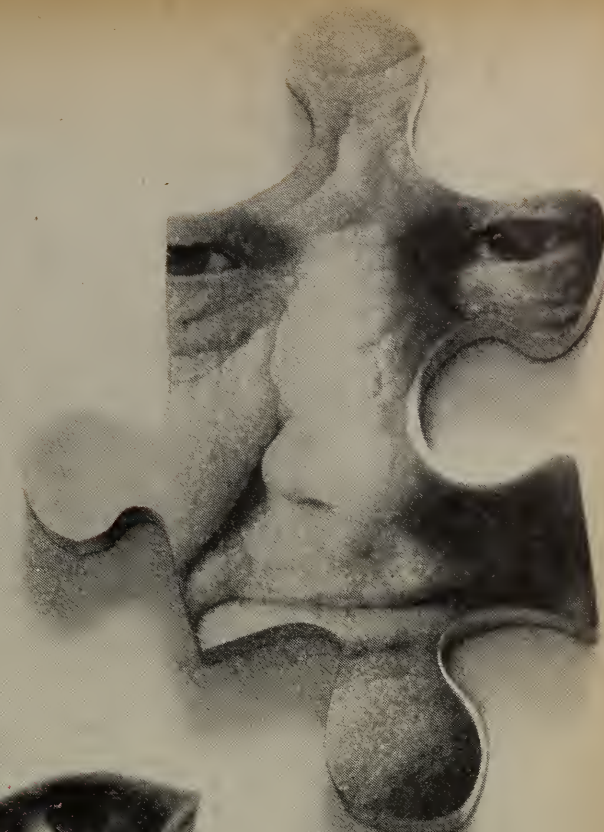
Long convalescence.

Illnesses which require that the patient remain in the hospital over a long period of time, whether he is strictly confined to bed, absolute bedrest, or up and about at will, often cause patients to tax the patience and ingenuity of the hospital staff, fellow patients, relatives, and the patient himself.

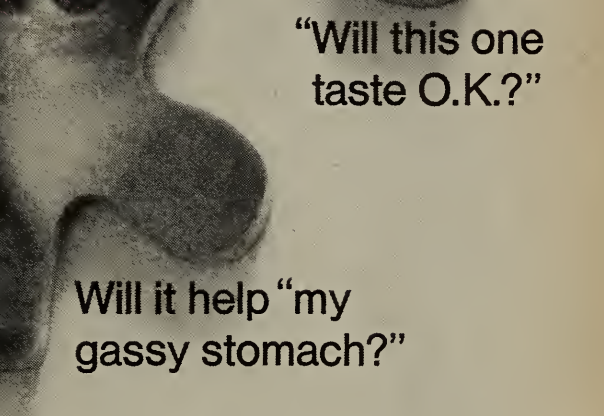
Many referrals to various individuals and departments will be made, and should in-

(Continued on page 104)

a puzzle of antacid complaints



"Will this one
taste O.K.?"



Will it help "my
gassy stomach?"



"Will it stop the pain?"

Mylanta[®]

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

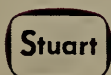
Effective neutralization—
with the two most widely prescribed antacids:
aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven¹ defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459
documented days of therapy.²

Composition: Each Mylanta chewable tablet or teaspoonful
(5 ml.) contains: magnesium hydroxide, 200 mg.;
aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed
to dissolve in the mouth) or one or two teaspoonfuls to be
taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.



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MEETING MEMOS

Jan. 18-20—"The Community and Emergency Medical Services" will be the theme of a national conference sponsored by the AMA at the San Francisco Hilton. All aspects of a community's emergency medical services will be discussed. Special emphasis will be placed on development of community councils on emergency medical services and ways and means of financing an emergency system.

Jan. 25-27—The Colorado Division of the American Cancer Society will sponsor the second annual Midwinter Cancer Seminar in Vail, Colo. Topics to be discussed include "The Critically Ill Patient" and "Clinical Genetics."

Jan. 25-27—The Northwestern University Medical Center and Passavant Memorial Hospital will present a post-graduate course in internal medicine entitled "The Year in Internal Medicine." The course will be given at Offield Auditorium and Passavant Memorial Hospital. Topics will be of especial current interest in pharmacology, physical medicine, gastroenterology, psychiatry, endocrinology, metabolism, hematology, infectious disease, and cardiology.

Jan. 27—A scientific meeting for specialists in internal medicine will be held at the Urbana-Lincoln Hotel, Urbana, Ill. It is sponsored by the American College of Physicians. Guest speakers will present "Exploring Medical Education of the Future," "The pursuit of Professional Competence," and "The Third Disease, the Internist's Dilemma." The meeting is under the direction of Edward W. Cannady, M. D., East St. Louis, ACP Governor of Illinois (Downstate) and Eliot E. Foltz, M.D., Winnetka, ACP Governor of Illinois (Northern).

Feb. 3-4—The American Academy of Allergy will present a two-day postgraduate course at the Statler Hilton Hotel in Boston. Saturday's sessions will treat "Viruses and Virus Diseases" while on Sunday "Antigens, Antibodies, Inflammation and Autoimmunity" will be the subject.

Feb. 5-7—The 24th Annual Meeting, American Academy of Allergy, Statler Hilton Hotel, Boston, Mass.

Feb. 5-7—Aspen Conference on the Newborn, presented by the Children's Hospital, Denver, Colo., at the Aspen Institute for Humanistic Studies. Registration fee is \$40, and is limited.

Feb. 13—Nobel laureate Frederick C. Robbins, M.D., Dean, Case Western University School of Medicine, will deliver the second Harold Jacobziner Memorial Lecture at Alumni Hall, New York University School of Medicine, New York City.

Feb. 15-17—The problems of teenage contraception will be given special emphasis at the "Advanced Seminar in Conception Control," New York University Medical Center, 550 First Ave., New York City. Sex education, community outreach of family planning centers, and sociological and demographic aspects of family planning will be presented through in-depth discussions.

Feb. 19-21—The Statler-Hilton, Dallas, Texas, will be headquarters for the American College of Surgeons Sectional Meeting. An intensive series of panels, "How I do it" clinics, symposia, papers, and films are designed to inform the medical profession at large about developments in surgery.

Feb. 20-23—The 32nd Annual Postgraduate Institute of the Philadelphia Medical Society will be held at the Bellevue-Stratford Hotel.

New Booklet on Drug Dependence

Widespread concern, particularly among alarmed parents, over the nation's rising drug abuse problem and the raging "front-page" controversy centered around the increasing use of LSD, marijuana and other hallucinogenic drugs by thrill, curiosity and "self-improvement" seekers on and off college campuses has spurred the AMA to develop a 25-page booklet, "The Crutch That Cripples: Drug Dependence."

The publication is designed to give the public a sound understanding of drugs, their uses and abuses and the problems which irresponsible use leaves in its wake.

The publication was prepared by the Committee on Alcoholism and Drug Dependence, Council on Mental Health, in response to heavy mail and telephone inquiries received in recent months by the AMA's Department of Mental Health.

Written lucidly and in colorful language readily understood either by parents or the younger set, *The Crutch That Cripples*, discusses all aspects of drug use.

OBITUARIES

***Dr. Arthur V. Bergquist**, Park Ridge, died Dec. 2 at the age of 70. He was on the staff of Ravenswood and Resurrection Hospitals.

***Dr. Joseph F. Biehn**, a former board member of Abbott Laboratories, died Dec. 8 at the age of 89. He was a member of the ISMS Fifty-Year Club.

***Dr. W. F. Buckner**, Watseka, died Nov. 4 at the age of 89. He was one of the founders of the Watseka Building and Loan Association; a member of Iroquois Hospital staff, a former secretary of the Iroquois Medical Society and a member of ISMS Fifty-Year Club.

***Dr. Colin Campbell**, Momence, died Dec. 6 at the age of 66. He was formerly associated with Grant Hospital, Chicago.

Dr. Herschel Cave, Jacksonville, died Dec. 19 at the age of 56. He was medical director at Jacksonville State Hospital.

***Dr. Kalman Gyarfazs**, former superintendent of Chicago State Hospital, died Nov. 24 at the age of 66. He was superintendent of the Chicago Mental Health Center and coordinator of the Garfield Park Comprehensive Mental Health Program.

***Dr. Joseph L. Hagan**, Northbrook, died Dec. 12 at the age of 79. He was a general practitioner in Evanston for 50 years and was a member of ISMS Fifty-Year Club.

Dr. Henry Heinen, Evanston, died Dec. 1 at the age of 86.

Dr. Odell Howell, East St. Louis, died Nov. 4 at the age of 47.

Dr. Alice Roberts Lang, Hinsdale, died Nov. 24 at the age of 62. She had been associated with the Universities of Chicago and Illinois and Johns Hopkins University.

***Dr. George E. Mueller**, former Oak Park commissioner, died Nov. 12 at the age of 75.

Dr. Maxim Pincus, Olympia Fields, died Nov. 26 at the age of 64. He was past president of the Rest Haven Home for the Aged.

***Dr. Otto Porges**, Chicago, died Nov. 20 at the age of 88. He was a pioneer in the use of insulin and was on the staff at Columbus Hospital.

***Dr. James H. Skiles Sr.**, Oak Park, died Dec. 10. He was a former staff member in the West Suburban Hospital and a member of ISMS Fifty-Year Club.

Dr. Frank Smith, former medical director of the Western Electric Company Hawthorne works died Nov. 21 at the age of 83. He served on the medical review board of the Selective Service Commission during World War I.

***Dr. James R. Smith**, Chicago, died Nov. 13 in Christ Community Hospital where he had been on the hospital staff since the hospital opened. He was a member of ISMS Fifty-Year Club.

Dr. Charles Russell Sudgen, retired Deerfield physician and former chief of Staff at Highland Park Hospital, died Nov. 24 at the age of 65. He was a past president of the Lake County Medical Association and was flight surgeon in the air corps during World War II.

***Dr. Paul Tachau**, Chicago, died Dec. 4 at the age of 80. He was a dermatologist and consultant at the Northwestern University Medical School.

***Dr. Alex Walker**, Chicago, died Dec. 8 at the age of 83. He was a former Secretary to the Calumet Branch of the Chicago Medical Society, Chief of Staff at Roseland Community Hospital, where he taught Anatomy and was chairman of the Executive and Surgical Committee.

***Dr. James D. Walsh**, Oak Park, died Dec. 7. He was a senior staff physician in Loretto Hospital.

***Dr. Martin F. Ziemer**, Chicago, died Nov. 20 at the age of 65. He was a graduate of the Stritch School of Medicine of Loyola University and was a staff member of Evangelical Hospital and Christ Community Hospital.

**Member, Illinois State Medical Society.*

* * *

During the 1968 Sesquicentennial of the State of Illinois, the *Illinois Medical Journal* will publish a series of articles on medical history and progress in Illinois during the last 150 years. Interested authors are invited to submit appropriate articles for this special series.

* * *

The number of veterans in civil life increased by 271,000 during the past year to a total of 25,846,000, the Veterans Administration reports.

Do you have patients who try to hide anguish behind arrogance?

They may be unable to face the pain of their depression.

The face, the bearing, the trappings may scream assurance, security, and remoteness from a world of little people with little pains and sorrows. But it's all a masquerade that hides the anguish and dread which threaten to tear them apart.

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

They want your help and Aventyl HCl can help you.

Whether depression is open or secretive, Aventyl HCl assists you in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.



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Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline
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(See last page for prescribing information.)

Opinions and Reports on Ethical Relations

Professional Association Laws

The Judicial Council considered the so-called "professional association laws" which would permit doctors to form professional associations. It was asked whether or not associations of doctors formed under this law would conform to the American Medical Association's Principles of Medical Ethics.

The Council pointed out that in 1957 the House of Delegates of the Association declared that it is within the realm of ethical propriety for physicians to join together in partnerships, associations, or other lawful groups, provided that the ownership and the management of the affairs thereof remain in the hands of licensed physicians. The Council agreed that in accordance with the policy of the House of Delegates, physicians may take advantage of "professional association laws" and may also ethically do those things which are necessary to reap the intended and proper advantage of such legislation. (Judicial Council, 1961)

Availability of Medical Services

Many forces are pressing for the adoption of new methods of medical practice and for changes in the relations of physicians, as individuals and as organized groups, toward the public and toward institutions and organizations, and also for revolutionary changes in the very traditions of the profession with respect to the obligations and privileges of physicians in their contacts with one another. These forces have in some instances been sadly misdirected and will result in disaster to medicine and to the public.

The complexities of modern society may make it imperative that some changes shall be made, but the duty of the organized profession is to see to it that any and all proposals for change, from whatever source, shall be scrupulously and deliberately examined with the view of determining their ultimate value. Decisions should not be made on the basis of feasibility for the immediate present but should be made in the light of the experience of the profession, the nature of its service, the imperative need for maintaining professionalism and the absolute necessity for unhampered

scientific advancement, and with the utmost regard for the best interest of the people. (House of Delegates, 1932)

Periodic Health Examinations and Vending Medical Services

Individualism in the practice of medicine is essential to success if one has in mind the interest of the patient and the encouragement of medical progress. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient. We cannot help but feel that the service of periodic health examinations, as conducted by commercial institutions, must inevitably result in the undermining of the confidence of the people in the ability of the practitioner.

While it is true that periodical health examinations are often of value and are to be recommended in a general way, we are inclined to regard the indiscriminate communication of the results of such examinations to the examined in the form of the statements that are commonly made by these organizations as unwise and often injurious to the individual who applies for examination. No organization is medically qualified or, in our opinion, justified in issuing to individuals applying for examination a routine statement of the results of the examination.

We believe that enough has been said to show the importance of the subject, and feel that it is incumbent on this body to devise ways and means of setting the public aright on the question of periodic health examinations, and to convince the people that the proper person to make such examinations and to give advice relative thereto is the family physician, aided, when necessary, by local specialists. (House of Delegates, 1924)

Periodic Health Examinations by Lay Organizations

The Judicial Council desires to express again its firm conviction that the benefits of scientific medicine cannot be adequately delivered to the individual through the medium of a third party, and that the

(Continued on page 104)

Ethical Relations

(Continued from page 103)

communication of results of physical examination and the general advice with which it should be associated should go directly from the individual physician to his patients. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient. (House of Delegates, 1925)

Hospital Privilege Tax

It has been brought to the attention of the Judicial Council that some hospitals have adopted rules whereby attending staff physicians are prohibited, under certain conditions, from accepting fees for professional services, though charges for such services are made and fees are collected and appropriated to their own use by these hospitals. In one instance, members of a hospital staff were prohibited from the collection of fees for services rendered to certain ward patients, who were required to pay for hospital accommodations and to pay for service rendered by members of its staff, the hospital retaining all money collected for its own use. The Judicial Council gave its opinion to the effect that such procedure on the part of a hospital is unethical. (House of Delegates, 1929)

ETHICAL RELATIONS COMMITTEE

Willard C. Scrivner, M.D., *Chairman*

J. Ernest Breed, M.D.

George E. Giffin, M.D.

William M. Lees, M.D.

Medicine and Religion

(Continued from page 92)

clude the chaplain, who may be able to assist by frequent visits to combat loneliness, to interpret to the patient the necessity for his treatment, to support him in his search for understanding, acceptance, patience and strength.

Hospitalitis.

Frequently patients lose all desire to get well and assume their normal places of responsibility in the world. They seem to enjoy being taken care of by the doctors and nurses and the hospital staff because it gives them a feeling of security which is unobtainable on the outside.

These extremely insecure people need careful treatment in order to preserve the integrity of their personalities. If the chaplain is made aware of the problem, he may be able to assist the other personnel of the hospital and the patient himself in coping with the situation.

Psychosomatic illnesses and neuroses.

Unless the chaplain is made aware of the situation in such patients, his ministry could run counter to what is good for the patient and what is being attempted by other members of the therapy team. Quite often religious misbeliefs or wrong use of religious practices are involved in the etiology of such illnesses, and the chaplain may be of assistance in the treatment and rehabilitation of the patient.

HOSPITAL-BASED GROUP

It is predicted that doctors will practice in groups based in hospitals in which they will provide services to families both as in-patients and out-patients. These groups will include specially trained nurses, social workers and physicians to provide the minimal medical services which families demand, while the specialists, including the family physician-practitioner, provide the more complex diagnostic and therapeutic services. With the declining number of general practitioners, it is felt that patients may learn gradually to accept from paramedical personnel diagnostic and therapeutic procedures previously administered only by physicians. This bureaucratic organization might well provide more personal care for the patient; more personal care might also be facilitated by mechanization in laboratory techniques, diagnostic examinations, record-keeping, etc. With such an organization there also would be less care in the hospital by these hospital-based groups; there would be more home care but fewer home calls by the physician.

Editorial Review, American Society of Internal Medicine, April 1967.

NEW

PHARMACEUTICAL SPECIALTIES

by Paul deHaen

NEW SINGLE CHEMICALS

PONSTEL Analgesic, Non-narcotic R

Manufacturer: Parke, Davis & Co.

Nonproprietary Name: Mefenamic acid

Indications: Short-term use in relief of pain in conditions ordinarily not requiring the use of narcotics.

Contraindications: Intestinal ulceration, women of childbearing age, children under 14 yrs.

Dosage: 500 mg. initially, then 250 mg. q6h, prn, for no longer than one week.

Supplied: Kapseals—250 mg., bottles of 100.

TALWIN Analgesic, Non-narcotic R

Manufacturer: Winthrop Laboratories

Nonproprietary Name: Pentazocine lactate

Indications: Relief of pain associated with: minor or major surgery, trauma, orthopedic conditions, dental procedures, active labor, urologic conditions or procedures, acute and chronic medical disorders. As preoperative or preanesthetic medication, as a supplement to surgical anesthesia.

Contraindications: Increased intracranial pressure, head injury, or pathologic brain conditions in which clouding of sensorium is undesirable. Not for children under 12 yrs.

Dosage: Pts. in labor: 30 mg. i.m., or 20 mg. i.v. two or three times. All others: 30 mg. i.m., s.c., or i.v., repeated every 3-4 hrs.

Supplied: Ampuls—1 cc.—30 mg. base, boxes of 10, 25, and 100 Disposable syringes—1 cc.—30 mg. base, boxes of 10 Vials—10 cc.—30 mg. base/cc., boxes of 1.

VIBRAMYCIN Hyclate Antibiotic-B & M spectrum R

Manufacturer: Pfizer Laboratories

Nonproprietary Name: Doxycycline Hyclate

Indications: Pneumonia; respiratory, genitourinary, soft tissue, ophthalmic, and gastrointestinal infections. Other infections caused by susceptible strains of gram-positive and gram-negative bacteria.

Contraindications: Hypersensitivity to doxycycline

Dosage: Adults—initial: 200 mg. (100 mg. q12h.) maint.: 100 mg. (as single dose or 50 mg. q. 12h.)

Children under 100 lbs.—2 mg./lb. divided into 2 doses, followed by 1 mg./lb. as a single dose, or divided into 2 doses.

Supplied: Capsules—50 mg. base, bottles of 50.

VIBRAMYCIN Monohydrate Antibiotic-B & M spectrum R

Manufacturer: Pfizer Laboratories

Nonproprietary Name: Doxycycline Monohydrate

Indications: Pneumonia; respiratory, genitourinary, soft tissue, ophthalmic, and gastrointestinal infections. Other infections caused by susceptible strains of gram-positive and gram-negative bacteria.

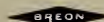
Contraindications: Hypersensitivity to doxycycline.

(Continued on page 106)

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For Iron Deficiency Anemia



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PERITINIC® Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate) .	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60



anticoptive, *adj.* (*anti* opposed to + *costive* causing constipation.)
Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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New Pharmaceutical Specialties

(Continued from page 105)

Dosage: Adults-initial: 200 mg. (100 mg. q.12h.)
maint.: 100 mg. (as single dose or 50 mg. q.12h.)

Children under 100 lbs.-2 mg./lb. divided into 2 doses, followed by 1 mg./lb. as a single dose, or divided into 2 doses.

Supplied: Dry powder for oral suspension-25 mg. base/5 cc., raspberry-flavored, bottles of 2 oz.

DUPLICATE SINGLE PRODUCTS

SOMBUCAPS Sedative & Hypnotic-Barbiturate R

Manufacturer: Riker Laboratories

Nonproprietary Name: Hexobarbital

Indications: Insomnia, interrupted sleep, pre-anesthesia, post-operative sedation, short-term sedation for diagnostic and minor surgical procedures.

Contraindications: Latent or manifest porphyria or a familial history of intermittent porphyria. Impaired hepatic or renal function.

Dosage: 1 to 2 caps. every 2-3 hrs., as necessary.
Supplied: Capsules-250 mg., bottles of 50

COMBINATION PRODUCTS

ALLBEE-T Vitamin Comb.-other o-t-c

Manufacturer: A. H. Robins Co.

Composition: Thiamine mononitrate 15 mg.

Riboflavin 10 mg.

Pyridoxine HCl 10 mg.

Calcium pantothenate 25 mg.

Niacinamide 100 mg.

Ascorbic acid 500 mg.

Cyanocobalamin 5 mcg.

Desiccated liver 150 mg.

Indications: Vitamin deficiency states, except pernicious anemia.

Contraindications: None mentioned.

Dosage: One or two tablets daily.

Supplied: Tablets-bottles of 100 and 500.

DRIXORAL Nasal decongestant R

Manufacturer: Schering Corp.

Composition: Dexbrompheniramine maleate 6 mg.
d-Isoephedrine sulfate 120 mg.

Indications: Upper respiratory mucosal congestion in seasonal and perennial nasal allergies, acute rhinitis and rhinosinusitis, acute and subacute sinusitis, eustachian tube blockage, and secretory otitis media.

Contraindications: Children under 12 yrs. of age, pregnancy.

Dosage: One tablet in the morning and one at bedtime. Exceptional cases may require one tablet q.8h.

Supplied: Tablets, sustained-release. Bottles of 50.

NORLESTRIN-1 mg. Progesterone/Estrogen Comb. R

Manufacturer: Parke, Davis & Co.

Composition: Norethindrone acetate 1 mg.

Ethinyl estradiol 0.05 mg.

Indications: Control of conception

Contraindications: Thrombophlebitis or history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breast or genital organs, undiagnosed vaginal bleeding.

(Continued on page 108)

Clinics for Crippled Children

Twenty clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 14 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Feb. 1, Lake County Cardiac—Victory Memorial Hospital
- Feb. 7, Carlinville—Carlinville Area Hospital
- Feb. 7, Rock Island Cerebral Palsy—Foundation for Crippled Children & Adults, 3808 Eighth Ave.
- Feb. 7, Hinsdale—Hinsdale Sanitarium

- Feb. 8, Rockford—St. Anthony's Hospital
- Feb. 8, Anna—First Christian Church
- Feb. 8, Springfield General—St. John's Hospital
- Feb. 9, Chicago Heights Cardiac—St. James Hospital
- Feb. 9, Evanston—St. Francis Hospital
- Feb. 13, East St. Louis—Christian Welfare Hospital
- Feb. 13, Peoria General—Children's Hospital
- Feb. 14, Champaign-Urbana — McKinley Hospital
- Feb. 15, Elmhurst Cardiac—Memorial Hospital of DuPage County
- Feb. 20, Belleville—St. Elizabeth's Hospital
- Feb. 21, Springfield Cerebral Palsy (P.M.) —Diocesan Center
- Feb. 21, Chicago Heights General—St. James Hospital
- Feb. 22, Bloomington—St. Joseph's Hospital
- Feb. 23, Chicago Heights Cardiac—St. James Hospital
- Feb. 27, Peoria General—Children's Hospital
- Feb. 28, Aurora—Copley Memorial Hospital



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1. Bradley, J. E., *et al.*: J. Pediat. 38:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. 20:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



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New Pharmaceutical Specialties

(Continued from page 106)

Dosage: 1 tablet daily, for 20 days beginning on the 5th day of each cycle.

Supplied: Tablets-bottles of 100, packages containing 5 folders of 20 tablets each.

NEW DOSAGE FORMS

CARDILATE Vasodilators-Coronary R

Manufacturer: Burroughs Wellcome & Co.

Nonproprietary Name: Erythrityl tetranitrate

Indications: Prophylaxis and long-term management of patients with frequent or recurrent anginal pain and reduced exercise tolerance.

Contraindications: None mentioned.

Dosage: 1 tab. tid, additional doses may be taken prior to anticipated stress, and at bedtime if necessary.

Supplied: Chewable tablets-10 mg., bottles of 100.

ROBINUL Injectable Antispasmodic R

Manufacturer: A. H. Robins Co.

Nonproprietary Name: Glycopyrrolate

Indications: Gastrointestinal disorders that will benefit from parenteral anticholinergic therapy, in cases when oral medication is not tolerated, or a rapid effect is desired.

Contraindications: Glaucoma, organic cardiospasm, achalasia of the esophagus, pyloric obstruction or stenosis with significant acid retention, obstructive or stenosing disease of the gastro-intestinal tract, urinary bladder neck obstruction and prostatic hypertrophy.

Dosage: 0.1 mg. i.m., at four hour intervals, 3 or 4 times daily.

Supplied: Ampuls-1 cc. (0.2 mg.)

Multiple dose vials-5 cc. (0.2 mg./cc.)

TARACTAN CONCENTRATE Ataraxic R

Manufacturer: Roche Laboratories

Nonproprietary Name: Chlorprothixene

Indications: Psychiatric disorders requiring a higher dosage.

Contraindications: Circulatory collapse, comatose states due to central depressant drugs, known sensitivity to the drug.

Dosage: Must be individually adjusted. Severe conditions usually require 25 to 50 mg. three or four times daily (up to 600 mg.)

Supplied: Liquid-100 mg./500 cc., bottles of 16 oz.

Psychotropic Drugs

(Continued from page 42)

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Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093—Telephone (312) 446-8440.

YOUR DRUGS AND THERAPEUTICS COMMITTEE REPORTS

In this column each month your Drugs and Therapeutics Committee of the Illinois State Medical Society will report on some facet of drugs and therapeutics.

The committee is comprised of Robert C. Muehrcke, M.D., Oak Park, chairman; Charles R. Frazer, M.D., East St. Louis; Joseph D. Cece, M.D., Oakbrook; Edsel K. Hudson, M.D., Chicago; Gordon Lucas, M.D., Rockford.

Consultants to the committee are Theodore Sherrod, M.D., Ph.D., Professor of Pharmacology, University of Illinois College of Medicine, and Mr. Louis Gdalmann, Director, Section of Pharmacy, Division of Medicine, Presbyterian - St. Luke's Hospital, Chicago.

The committee's aims are to present to members of the Illinois State Medical Society a quality report on a variety of specific and comprehensive subjects related to drugs and therapeutics. This column will bring the practical knowledge on therapeutics from the Medical Center to the practicing physicians. From time to time, guest contributors will be invited to discuss a specific therapeutic subject. The following material is planned for future presentation:

Adverse Drug Reactions

Discuss Groups of Drugs as to Therapeutic Effects

Oral Diuretic Agents

Newer Therapeutic Agents

Evaluation of Therapeutic Regimens

Evaluation of Drug Therapy

Use of "3 in 1" Antihypertensive Agents

Utilization of Drugs Not FDA Approved

Positive Views About Excellent Therapeutic Drugs

Pharmacology of Drug Combinations

Over Prescribing by Physicians

Prescribing Habits of Physicians

Chronic Drug Therapy

Drug Interaction

Generic Drugs—Their Quality and Relative Costs

The committee invites suggestions from the society membership for future reports. Please write to the following:

Drugs and Therapeutics Committee
Illinois State Medical Society
360 N. Michigan Ave.
Chicago, Ill. 60601

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 SPECIALTY REVIEW COURSE IN THORACIC SURGERY, April 1
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates

PROCTOSCOPY & VARICOSE VEINS, One Week, March 18
 ESSENTIALS OF PLASTIC SURGERY, One Week, April 1
 FLUIDS & ELECTROLYTES, One Week, April 22
 ARTERIOGRAPHY, Four Days, March 19
 ADVANCES IN FRACTURES & ORTHOPEDICS, March 11
 VAGINAL APPROACH TO PELVIC SURGERY, One Week, March 4
 GYNECOLOGY, Office & Operative, One Week, March 25
 OBSTETRICS, General & Surgical, One Week, April 1
 RADIOISOTOPES, One or Two Weeks, First Monday each Month

BASIC ELECTROCARDIOGRAPHY, One Week, March 11
 BASIC INTERNAL MEDICINE, One Week, April 22
 CLINICAL NEUROLOGY, One Week, April 22
 ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

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Anesthetic Complications

(Continued from page 36)

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—THE VIEW BOX—

(Continued from page 53)

DIAGNOSIS: RESIDUAL GROWTH RETARDATION FROM SICKLE CELL DACTYLITIS.

This patient is a known case of sickle anemia of SS type hemoglobin. Previous history disclosed an episode of painful swelling of the affected digits and toes as an 18 month old infant.

Cockshott has described the residual dactylitis as follows:

- (1) Conical shaped epiphyses.
- (2) Triangular shaped epiphyses.
- (3) Early fusion with relative shortening.

Trueta has shown that ossification at the epiphyses can only proceed in the presence of an intact blood supply. In sickle cell disease the diaphyseal vessels become occluded by sickled cells, edema or thrombosis. The perforating vessels which arise directly from the periosteal circulation remain patent allowing peripheral growth, thus leading to selective suppression in growth, and cone shaped epiphyseal deformities. Premature epiphyseal closure also occurs with resultant shortened thickened digits.

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BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 2

February, 1968

Blue Shield's Usual and Customary Plan Grows

Last May Blue Shield obtained approval from the Illinois State Medical Society's House of Delegates to apply the Society's definitions of "Usual, Customary, and Reasonable" fees to new Blue Shield accounts and to make payments to physicians on that basis.

It has been over six months since the first Usual and Customary program went into effect covering nearly 60,000 employees of United States Steel and Bethlehem Steel.

During this time many other groups have enrolled in Blue Shield's Usual and Customary program including the American Medical Association's 950 employees.

The Health Improvement Association is the largest single group in Illinois to enroll its 70,000 members in our Usual and Customary program.

To familiarize Illinois physicians with our Usual and Customary program, letters from John C. Troxel, M.D., Medical Director, Blue Cross-Blue Shield were mailed to County Society Secretaries and Presidents requesting the opportunity to meet with members of the County Society—and branches of the Chicago Medical Society—to discuss the Usual and Customary concept with its members.

So far thirty-five County Medical Societies and branches of the Chicago Medical Society have extended invitations to be on their programs. We welcome the opportunity to discuss matters of mutual concern with members of the State Medical Society and look forward to many more meetings of this type.

Blue Shield is making every effort to develop "Usual and Customary" into a workable practical solution to meet the demands made upon medicine and to respond to changing conditions and changing needs.

Properly carried out, and with the understanding and continued cooperation of the medical profession, the Usual and Customary program will accomplish several long desired objectives: a greater return for physicians from third-party agencies; a more appropriate share of the prepayment dollar; a greater return to the public in benefits provided; and predictability of medical charges to the consumer.

State Society & Blue Shield T.V. Series Underway

The 13 week T.V. series on pre-retirement planning sponsored by the Blue Shield Plan of Illinois Medical Service and the Illinois State Medical Society is off to a good start. Taping of the series, entitled "The Time of Your Life," began February 3.

Mr. Norman Ross, well-known Radio and T.V. personality will host the shows.

The first show outlines the subjects to be discussed on the remaining twelve which include financial planning, health care coverage, housing, estate planning, preventive health care, aspects of aging and chronic illness, medical quackery, emotional change in aging, how to get the most out of leisure, community activities, the surviving spouse, and the retiree's family.

This public service is produced by WTTW, channel 11, Chicago's educational station. The series will first be telecast from channel 11 starting in April, and will be shown by other educational channels throughout the state.

The series will also be made available to employers interested in preparing their employees for retirement. Many groups have expressed enthusiasm over the joint undertaking by the State Society and Blue Shield.

(usual & customary con't)

To help prevent delay in making payments to physicians treating Blue Shield subscribers with Usual and Customary, it is important for us to know the date of service; the service rendered; and your usual fee for the service. Do not combine fees for several services. Payment is made on the basis of the Illinois State Medical Society's definitions of Usual, Customary, and Reasonable, reprinted in the October 1967 issue of this *Report*. The definitions also appear in the July 1967 issue of the *Illinois Medical Journal*.

If you or your medical assistant have any questions regarding this or other Blue Shield matters, please contact Mrs. Loretta O'Donnell, 425 North Michigan Avenue, Chicago, Illinois 60611.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

The Social Security Amendments of 1967 increase Medicare benefits and change program procedures. Among key changes, the amendments eliminate the receipted bill requirement for payment of non-assigned claims under Part B and remove initial physician certification for hospitalizations and outpatient services. Among the provisions, the amendments will allow 100% payment of "reasonable" charges for inpatient radiology and pathology services provided by physicians. The amendments add 60 days of inpatient hospital care and increase outpatient physical therapy benefits.

Unreceipted itemized statements can now provide the basis for payment to Medicare patients whose physicians do not accept assignments. The change, effective since January 2, 1968, was brought about by the American Medical Association's request to facilitate payments to Medicare patients financially unable to pay physicians not accepting assignments.

The procedure remains the same for those physicians who do accept assignments.

Physicians certification of medical necessity for admissions to general hospitals and nearly all outpatient hospital services has been dropped as of January 2. Certification is required by the 14th day of inpatient general hospital services. *Initial* certification is still required for admissions to psychiatric and tuberculosis hospitals and to extended care facilities.

100% of reasonable charges can be made to physicians who provide radiology and pathology services to inpatients of participating hospitals, beginning April 1 of this year. These services will then be covered under Part B of Medicare which should facilitate hospital billing procedures and reduce paperwork. The \$50 annual deductible will not have to be met.

All outpatient hospital benefits will be covered under Part B beginning April 1. This change in the law eliminates the necessity of separating diagnostic from therapeutic services which was a previous requirement and permits a single deductible and co-insurance applied to all covered outpatient hospital services.

Additional outpatient physical therapy services will be covered under Part B beginning July 1 when furnished by qualified "providers of service" (approved clinics, rehabilitation centers, public health agencies) and when a physician certifies that the patient requires physical therapy on an outpatient basis and when a physician establishes and periodically reviews the plan of treatment. At present, physical therapy services are covered when furnished under the direct supervision of a physi-

cian or to homebound patients under a home health plan.

Sixty additional inpatient hospital benefit days can be paid for at the patient's option during his lifetime whenever the 90 hospital days under Part A have been exhausted in a "spell of illness." This provision became effective January 1. The 60 day "lifetime reserve" is not renewable and is permanently reduced by the number of days used. For each day used there is a \$20 co-insurance.

Payment on Itemized Bill

A physician who does not accept an assignment and submits an *itemized bill* to his Medicare patient, should include on each bill the patient's name; the physician's name; the date, place, description of EACH service provided and the charge for EACH service. Unusual circumstances or complications should be described if they are reflected in the charge. This information is needed before payment can be made to Medicare patients for covered services.

The 1967 Amendment to Social Security which allows a payment to be made on an *itemized* rather than a receipted bill is intended to provide the Medicare patient with the resources to help pay his physician's charges. *But, it also increases the possibility of duplicate payment being made for the same service.* It is possible, for example, for a physician to accept an assignment at the same time his patient submits an itemized bill for payment.

A physician who accepts an assignment will not be paid when the benefit has already been paid to his patient. Likewise, no payment will be made to his patient when the benefit has been paid to the physician.

When a Medicare patient's claim is received first, payment will be made to him. When a claim from a physician who accepts an assignment is received before payment is made to his patient, payment will be made to the physician.

Therefore, physicians who do accept assignments should submit claims promptly for services they have provided. And to reduce the possibility of duplicate claims from being filed or duplicate payments from being made, they should clearly indicate on their patient's bills that they accept assignment.

NOTICE

Physicians in the counties of Cook, DuPage, Kane, Lake, and Will who accept assignments may request a supply of SSA 1490 *Request for Payment* forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

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Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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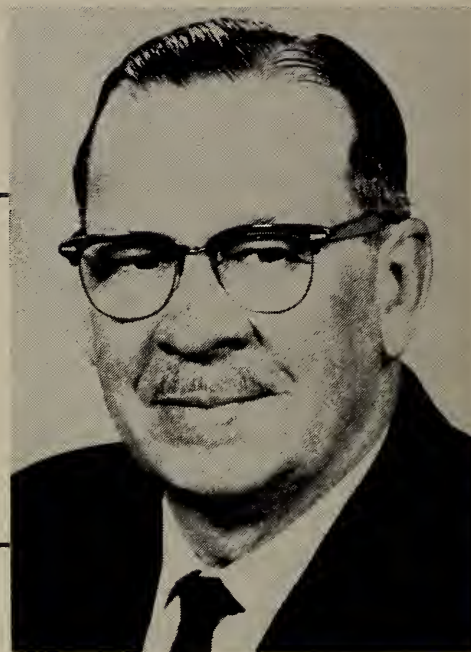
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Newton DuPuy, M.D.

Getting away from the telephone is a periodic necessity for any physician who values his sanity and many of us dream of the day when we can take the time to make the escape worthwhile by taking a long, relaxing trip around the world.

In view of the government's current attitude toward international travel and the proposed tax on such trips to discourage them, going around the world may remain in the dream category for some time.

But dreams sometimes come true and an interesting kind of game is mentally packing one's bags for a dream trip. Anyone taking a trip around the world has the problem of deciding which of his belongings must go into the weight allowed by overseas airplanes, but the physician's problem is complicated by the fact that while he may be a tourist, he is also a doctor and it is incomprehensible that

he would not want to take along some emergency medical supplies—all of which must be counted in 66 pounds of luggage he is allowed to take if he goes first class or 44 pounds economy class.

Of course, the doctor might find himself in places where he might not be able to practice medicine as such so that there would be no need to take along everything he carries in his bag at home, but even if his services were limited to his immediate family, he would certainly want to take along certain first aid items.

Beginning by weighing each band-aid as he packed it, what else should he take? I'd like to hear what others have done about this problem. Will you let me know your experiences? Or if you haven't had occasion to come to grips with such a problem, I'd be interested in the medical items you would suggest packing.

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Early Obstetric Practice In Illinois

FREDERICK H. FALLS, M.D./RIVER FOREST

PART I

It may be of interest to briefly review the practice of obstetrics in Illinois before the white man arrived. In order to complete the picture it is necessary to include certain facts concerned in human reproduction before the coming of the white man. Gathering such information is difficult because of extreme reticence of the Indians to discuss these subjects with white people.

During menstruation, pregnancy and the puerperium, the Indian woman was looked upon as sacred and superhuman. It was assumed that her condition revealed a magic power so potent that, if not separated from the ordinary haunts of man, it would disturb the normal course of nature.

A common impression prevails in modern times that the menial and hand work of tilling the soil and harvesting the crops was put upon women because it was beneath the dignity of the men who were hunters and warriors. This is far from the truth. The sowing of seed by women was supposed to render such seed more fertile and the earth more productive than if planted by men, for it was believed that women have and control the faculty of reproduction and increase. Hence, sowing

and cultivating crops became one of the exclusive departments of women's work.

Confinement among many tribes took place in a new and specially constructed shelter. This was about 8 feet in diameter and was made of boughs supplemented by strips of canvas or skins during seasons



During 1968, the Sesquicentennial of the State of Illinois, a series of articles on medical history will be published in the *Illinois Medical Journal*.

This article is the second in that series. It was first presented at the 21st Annual D. J. Davis Lecture on Medical History, April 8, 1964 at the University of Illinois College of Medicine.

Interested authors are invited to submit appropriate articles for future issues.

when leafy boughs were not available. The structure was destroyed after labor. In some instances a more pretentious building was erected which was used by all the women of the tribe during labor; this may have been the first lying-in hospital. In preparation for labor, two trenches about 10 to 14 inches wide were dug. One contained hot stones over which the parturient squatted, (thus producing sterility) and the other was used for the disposal of excreta (avoidance of contamination). In this way ex-

posure to infection was minimized. It was customary to build these lying-in quarters in the vicinity of running water when possible.

This provided an opportunity for the puerpera to bathe herself and her baby soon after delivery with a minimum danger of infection since running water tends to sterilize itself. Hemorrhage was treated in some tribes by squirting cold water on the abdomen or immersing the patient in cold running water (stimulation of sympathetic nerves), causing uterine contractions and constriction of uterine arteries.

Transverse presentations were among the most serious complications of labor in the Indian women, usually ending fatally due to uterine rupture. The outcome was accepted philosophically by the Indians who blamed the malposition on the baby and assumed that, because it was so evil, the tribe was better off than if it had been born alive and developed into a trouble-maker in its later life.

General Medicine

In order to understand the specific problems that confronted the early obstetrics practitioners, one must view the general field of medicine of that period. Nothing was known about bacteriology as such and its relationship to the practice of medicine. Organisms were known to exist, but their significance in obstetric and gynecologic problems was just beginning to be sensed by pioneer thinkers like Oliver Wendell Holmes in 1843 and Semmelweis in 1847. It is also significant that often the views of such men were bitterly opposed by the foremost obstetricians of their times, not only abroad but also in this country. This opposition hindered the acceptance of practices aiming at the control of puerperal infections and cost thousands of lives.

Prenatal care was practically unheard of. Even in Chicago and the larger centers there were no special provisions for obstetric care in any of the hospitals. Epidemic diseases prevailed but their causes were only guess work. In one instance an epidemic of erysipelas raged in Moline, Illinois for three months and all the pregnant women who delivered in that community during that period (20 in number) died of puerperal sepsis. Public health and sanitation, even in the crudest form, were almost unknown.

MEDICAL EDUCATION

Illinois was fortunate in having close medical relations and access to two large cities, namely St. Louis, Missouri on the Southwestern edge of the state, and Chicago in the Northeastern portion. Evansville, Indiana, on the Southeastern border, had a medical school which furnished some degree of interest in medical education and progress to Illinois. Chicago's rapid growth attracted many able physicians who had come for the most part from New York, Philadelphia, Boston and Cincinnati, and brought with them the pattern of medical education current in these centers. They were sadly handicapped in their teaching by almost complete absence of clinical material. The student attended a few lectures but there were no deliveries to attend, no pregnant women to examine and no labors to be witnessed. Books on the subject were, as a rule, hard to obtain and in most cases poorly written. Libraries were absent from all but the larger centers.

The rise of specialization in obstetrics and gynecology began with the rise of the medical schools: Rush Medical College in 1843, the Illinois College at Jacksonville in 1843, and the Chicago Medical College in 1859. The men who were called to the Chairs of Obstetrics in these centers during the 1850 period varied greatly in training and knowledge. They had moved Westward, impelled by the pioneer spirit of the times to seek their fortune in the rapidly expanding development of the Mississippi Valley.

It may be said, then, that the general pattern of obstetric practice during this early period was that of the general practitioner delivering patients in the home and meeting complications as best he could with the meager facilities available. He had no trained assistants, either nursing or medical, to aid him, anesthesia was not in general use, and the mortality rates for mothers and infants were high.

By 1880, according to Dr. G. W. Nesbitt of Sycamore, Chairman of the Committee on Obstetrics of the Illinois State Medical Society, medical education had advanced steadily in most other branches but had lagged behind in obstetrics. He felt that each medical school should have a lying-in hospital attached where undergraduate and postgraduate students could serve in



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outpatient delivery service for which a special fee could be charged; that patients be required to register for this service one month before going into labor; that the service be under the direction of competent instructors and that a special clause on the diploma of the medical student would testify to the fact that he had had practical training in midwifery under their direction. Thus, it is seen that a small town country doctor in Illinois in 1880 was farther ahead in his thinking on proper teaching of obstetrics than anything that had been proposed or at least had been put into operation in this country up to that time.

Formal postgraduate instruction in obstetrics and gynecology was begun with the formation of the Chicago Polyclinic at La-Salle St. and Chicago Ave., in 1886. It grew to have 30,000 patients and 250 students a

year.

Two years later (1888) the Postgraduate Medical School of Chicago was founded and it became associated with the Chicago Medical College which later became the Northwestern University Medical School. These schools were the first to provide specialized training for men practicing in communities around Chicago and in the Middle West, and who had previously been forced to go to one of the eastern cities or to Cincinnati or St. Louis for such instruction. Returning from these refresher courses, which consisted largely of lectures, demonstrations and operative clinics, these men were considered specialists in the communities where they were practicing.

Dr. Joseph B. DeLee graduated from medical school in 1891, and the notes he made as a student at the Chicago Medical College indicates some of the teaching

handicaps of the time. There was no provision for demonstrating obstetrical clinical material to undergraduates. To offset this the students would make up a purse by passing the hat; half of the sum collected was given to the patient whom they had persuaded to come to the school for delivery before the class by Dr. Jaggard (then Professor of Obstetrics). The other half went to Mercy Hospital for her postpartum care. Later, Jaggard, by clearing out bones, skeletons and anatomical dissections from a room under the anatomical amphitheater, acquired a space large enough to house two beds. Women were delivered in the amphitheatre, after the cadavers were removed. After delivery they were kept in the two-bed obstetric ward under the amphitheater. The janitor fed these patients, and visiting nurses bathed the babies and dressed the mothers. The following week they would be wheeled back into the pit and Dr. Jaggard would demonstrate the physiology and pathology of the puerperium and of the newborn. Occasionally, a student could induce a motherly old woman to let him deliver her at home. This practice was forbidden by the school after a lawsuit was filed against it by the husband of a woman who died of puerperal infection after such a delivery.

At his graduation in 1891, Dr. DeLee's total undergraduate experience in obstetrics was seeing two deliveries by the aid of opera glasses from a high seat in the anatomy amphitheater. The majority of medical schools of that day furnished even less instruction in obstetrics.

The decade from 1880 to 1890 saw the further development of medical schools. Also some men were able to devote a considerable portion of their time and energy to teaching or in training themselves in certain branches of clinical medicine beyond what was offered in the ordinary medical school course. Thus they may be looked upon as the first trained specialists.

HOSPITALS

Specialization in obstetrics and gynecology received great impetus from the organization of staffs to man the new hospitals that were being built, and especially those which were connected with medical schools.

There is no mention made of the use of the City Hospital (forerunner of the Cook County Hospital) which opened in 1859 as an institution equipped to accept obstetric

patients. In 1869, Dr. William E. Quine was the second intern appointed to the Cook County Hospital. Describing the obstetric service of that time he said: "Bacteriology and hematology were undeveloped and asepsis was unknown. Interns engaging in postmortem work or who were in touch with erysipelas or gangrene were assumed to have no connection with obstetrical cases, but there was no stern rule against it, and they thought no ill of maintaining friendly relations with 'laudable pus.' Puerperal infections were frightfully frequent and deadly, and the obstetrical ward was closed on two or three occasions for several weeks on account of them. During these intervals the windows were kept wide open night and day. Atomizers were kept busy sputtering weak antiseptic vapors into the atmosphere. Walls and ceilings were freshly whitewashed and all woodwork was scrubbed with antiseptic solutions, but the old deadly ignorance of personal transmission of infection continued."

The Woman's Hospital Medical College was founded in Chicago in 1870, later to be known as the Woman's Medical College and still later Northwestern University Woman's Medical School. The Presbyterian Hospital organized its Medical Board in 1884.

In 1894, the Chicago Maternity Hospital and Training School for Nurses was organized by the Directors of the Children's Aid Society of Chicago, whose ideal was to teach young mothers the care of their babies, and to keep mothers and babies together. It was the first institution dedicated to maternal welfare in the State of Illinois.

The Chicago Lying-in Dispensary was opened at noon on February 14, 1895. The staff consisted of Dr. Joseph B. DeLee and a Dr. Florence N. Hamiafar who served as matron.

In June 1899, the Chicago Lying-in Hospital was opened in a rented house at 294 S. Ashland Ave., Chicago. There was strong opposition by the people owning property in the immediate vicinity who felt that the presence of such an institution would depreciate the value of their property. An appeal was made to Mayor Carter Harrison of Chicago to prevent the opening of the institution, insinuating that Dr. DeLee was promoting it from purely selfish motives. However, the Board of Directors of the institution were sufficiently influential to overcome this resistance and thus the forerun-

ner of the present Chicago Lying-in Hospital was established. It, plus the ghetto dispensary, soon began to fulfill the important function of providing educational facilities for the training of obstetric specialists, both doctors and nurses.

In 1878, William H. Byford, who was then a founder member of the American Gynecological Society, called together at his home a group of physicians interested in the specialty of obstetrics and gynecology to organize the Chicago Gynecological Society.

Candidates for admission were required to have engaged in the scientific and practical development of gynecology or obstetrics for five years. The foremost teachers and research men of the specialty in this area have since been active in the work of the Society, and have assumed a prominent place in the ranks of similar organizations in other parts of the state, and in the United States.

1850 — 1860

What was thought to be the first recorded case (1853) of development of the placenta in the fallopian tube in Illinois by Dr. C. N. Andrews of Rockford, probably was a pregnancy in an arcuate type of bicornuate uterus. The patient delivered a small child, following which she had a retained placenta and a severe postpartum hemorrhage. The placenta was removed piecemeal by instruments and the hemorrhage controlled by a pack. The same result was encountered with her second pregnancy and again with severe postpartum hemorrhage. With her third pregnancy, while walking in the garden, she suddenly was seized with a severe pain, then fainted and died almost immediately. Autopsy showed a rupture of the uterus, possibly predisposed to by the previous manipulations necessary for instrumental removal of the placenta in the two previous pregnancies. The fact that the autopsy report did not mention the type of bicornuate uterus probably means that the degree of deformity was minimal.

In 1857, Dr. W. M. Chambers of Charleston reported on a condition called "stomatitis materna." This is probably the first mention in Illinois of vitamin deficiency disease during pregnancy. He stated that gestation and nursing caused

the disease since non-pregnant and non-lactating women did not have it. He noted also that the entire nervous system is sympathetic with the pregnant uterus and that the manifestations of the disease were brought about by "shattering the nervous system." He thought that it must be a blood disease, not due to any poison but to the blood, or to a portion of its constituents being below the standard of normal gestation. He quoted Simon who had examined the blood of nine pregnant women and found that pregnancy exercised a marked influence on the composition of the blood, in that the density of defibrinated blood and serum diminished, and water, fibrin and phosphorized fat increased, and corpuscles and albumin were diminished. This was probably the earliest mention, at least in Illinois, of disturbed water balance during pregnancy.

Anesthesia (chloroform) had been discovered in 1847. It is, therefore, astonishing to note that in 1859 a series of 500 cases delivered under chloroform anesthesia was reported by Dr. D. W. Young. A careful analysis was made of the advantages and dangers of the procedure, and recommendations were made for its use which might well be used today in obstetric cases. The dangers of the production of desultory labor were pointed out, together with the tendency to uterine relaxation postpartum predisposing to hemorrhage. The deleterious effect on the new born baby was also emphasized with special mention of deaths due to respiratory failure. Dr. Young claimed that if chloroform were judiciously administered, by putting it on a loosely folded silk handkerchief, in amounts just sufficient to stop pain, it would safely and successfully alleviate and annihilate the suffering incident to childbirth. When given in this way, no ill effect was noted on the baby or mother, and in no case in his series did the anesthesia have to be discontinued. He used about 6 ounces in six hours of labor.

Some practitioners, however, condemned the use of anesthesia in any case, implying that pain is a necessary accompaniment of labor. Others hailed it as a great boon to suffering womanhood and used it to excess. Most of the men of this day, however, agreed that anesthesia had a place in obstetrics and should be used cautiously for

analgesia and only rarely for complete anesthesia. Evidently the bad effect of morphine to relieve the pains of labor was well recognized, since it is seldom mentioned in their discussions on anesthesia.

1860 — 1870

Relatively little information can be gleaned from this decade as medical practice and teaching were so disrupted by the Civil War. However, it is significant that all deliveries, except major obstetrical operations, were done in the home since there were then very few hospitals in the state and these were largely intended for surgical cases. As already stated, bacteriology was practically unknown and, of course, not taught in any medical school. There was no electric light or other strong illumination. All obstetric operations were done on a low bed or on a kitchen table, without proper anesthesia, and with the untrained assistance of the husband or neighbor women in the majority of cases. Few of the doctors had any surgical experience or training, except that gleaned from injuries treated in their own practice or that of a colleague. Picture the plight of one of these general practitioners alone with his patient's family in a lonely farm house at 3 a.m.; an exhausted woman in labor about whose physical make-up he knew nothing and whose baby is showing signs of severe distress. A difficult forceps delivery is indicated which would try the skill and exhaust the strength of a DeLee or Williams, but this practitioner was forced into doing an operation which he knew he was incompetent to do.

Thus can one arrive at a realization of what obstetrics of that day might imply.

Some of the men, even at this early time, had a keen insight into the basic problems of obstetrics. For example, Dr. DeLaskie Miller, Professor of Obstetrics and Diseases of Women and Children at Rush Medical College, writing on puerperal sepsis in the years 1861-1864, thought the cause was "zymotic." He advised that parturient females should not be placed contiguous to patients with puerperal fever, erysipelas or gangrene. He held that the disease spread from contact with clothing, the surface of the body and the breath of attendants. He questioned the advisability of having a lying-in hospital, and felt that

most women were safer if delivered in a cabin. He felt strongly that physicians should give up caring for infected cases if they were to take care of pregnant women. In his opinion, bloodletting, which was freely practiced at this time, was worthless in puerperal disease. Miller advised that chlorine solution be used in the vagina or even in the uterus, either in the form of vapor or solution, but he relied chiefly on general support.

Eclampsia at this time was considered to be best treated by vena section, and chloroform was administered both pre- and post-partum. Twenty-five percent of the women who developed this disease died.

A paper by Dr. B. H. Cheney in 1869 indicated that placenta previa centralis was treated in the following manner; a tampon was put into the uterus to detach the placenta and chloroform was given to relax the os. The patient had been taking whiskey as a stimulant. As soon as the cervix was sufficiently dilated, a Braxton-Hicks version was done. The baby often died and the patient barely recovered after a "fearful" loss of blood. The mortality incidence of this condition at this time was one out of three mothers and 50 percent of the babies.

1870 — 1880

In the decade from 1870-1880, the management of obstetrical hemorrhage seemed to occupy more and more the attention of physicians interested in obstetrics. In 1873, blood transfusion was just beginning to be tried in England and France. Controversy arose regarding the effects of this procedure, especially when animal blood was given human recipients. Serious reactions were often noted and the procedure, therefore, was not endorsed by the obstetricians as a safe method to combat hemorrhages. Ponfic, for example, noted hemolysis of red cells in a woman who died twenty minutes after transfusion with lamb's corpuscles.

Dr. J. B. Rood, in 1873, described the method of combatting postpartum hemorrhage by the injection of perchloride of iron in the uterus. Hot water injections were also used for postpartum hemorrhage, the water being kept at 100° F. Cold water had been found ineffective. Hot water was also used for controlling hemorrhage from abortion, placenta previa, fi-

broids and carcinoma, and in cases of menorrhagia.

In 1875, Dr. Joseph W. Freer reported on blood transfusions, including the use of defibrinated blood and artery-to-vein direct transfusion. Blood transfusion was also used in anemias and tuberculosis. In some instances, blood was stored 72 hours in the ice-box before use. Thus we see the germination of the idea of the blood bank. Early in the study it was noted that deaths occurred from hemolysis of blood cells in some cases. Fatal transfusion reactions were known long before the principles of blood matching were worked out and before the dangers of the procedure were clearly recognized. This caused the procedure to fall into disrepute. It is much to the credit of these early pioneer obstetricians that blood transfusion did not then come into general use in obstetric cases.

In his paper Freer said that in case of danger from acute hemorrhage "so certain is transfusion of normal blood to resuscitate and restore life that we feel warranted in asserting emphatically that the practitioner in charge is under the most sacred obligation to perform this operation of transfusion. Moreover, once acquainted with his duty under such circumstances

he should lose no time in acquiring, if he has not already, both means and skill to meet all emergencies of this kind." Direct transfusion was carried out by Freer by means of a rubber tube with a bulb attached to the center permitting aspiration and expulsion of blood.

Physicians were also interested at this time (about 1875) in the diagnosis of sex in utero by means of the heart beat. Several papers written after a careful study of the subject condemned the method as useless.

Dr. L. B. Slater, in 1876, made a study of mortality in placenta previa in Illinois. He quoted a mortality of 1 in every 3.6 cases in England using version. About this time Simpson suggested the advisability of dilating the cervix manually, detaching the placenta and doing a version and extraction; he reported a mortality of 1 in 14. Barnes at this time in England reported an 11 percent mortality when expectant treatment was used. A tampon was placed in the vagina and the patient kept at rest in a horizontal position until delivery. All the babies of these cases died. Slater also suggested that blood transfusion would be useful in such cases but had not used it.

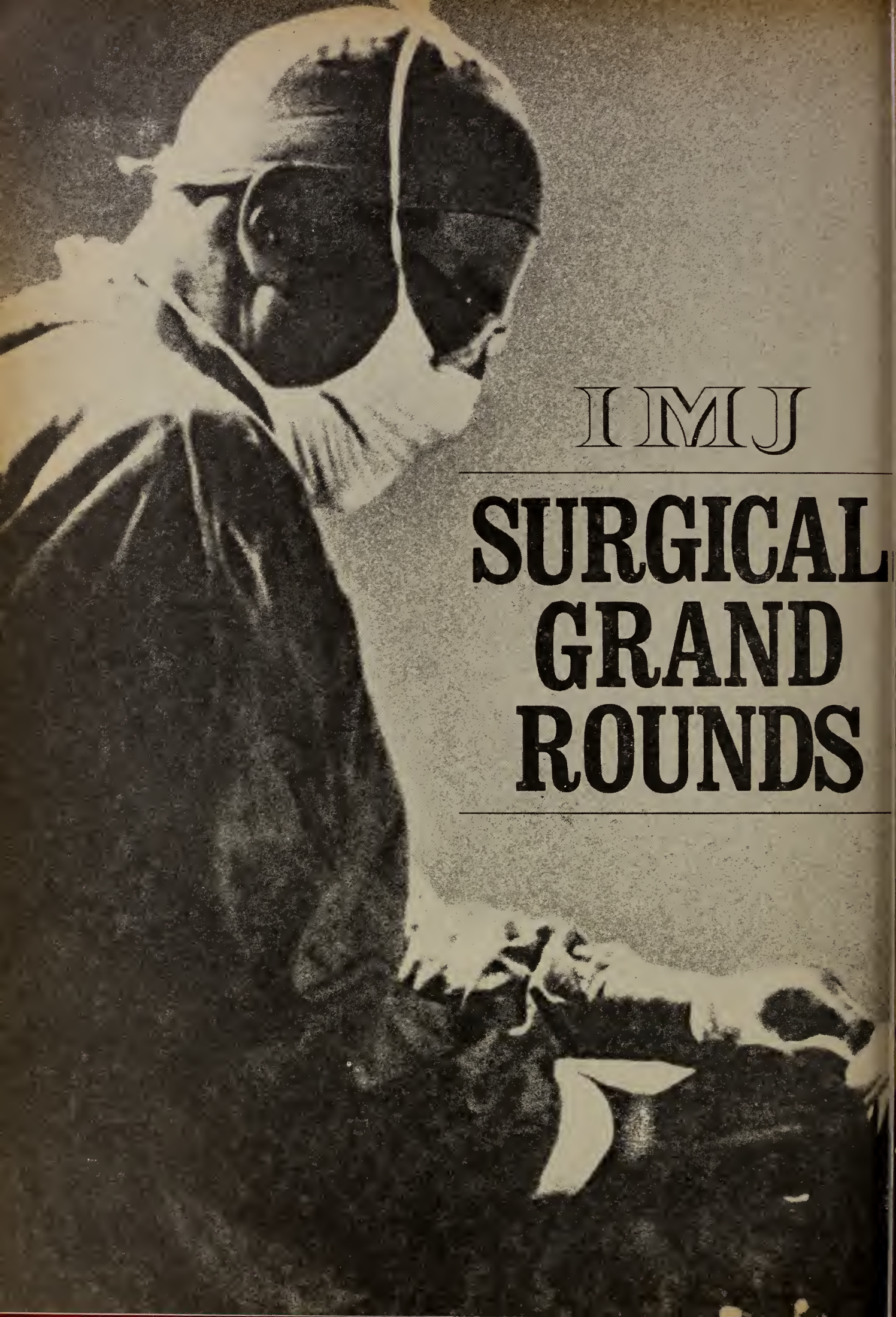
To Be Continued Next Month

CORNEAL AND LENTICULAR CHANGES

A clinical investigation of the corneal and lenticular changes from long-term chlorpromazine therapy was conducted at the East Louisiana State Hospital for the mentally ill. One hundred and seventy consecutive patients were examined. The only criterion was that the patient be taking chlorpromazine (Thorazine) at the time. Fifty-one patients (30%) were found to have positive findings, of whom 29 had changes in the lens only, 22 had both corneal and lenticular changes, the latter including three who had skin discoloration. None were found with corneal or skin changes alone.

The earliest change appeared to be a tiny golden brown stelliform body of pigment on the anterior surface of the lens. A more advanced change was a diffuse dust-like stippling of brown pigment on the anterior surface of the lens, progressing to the "typical" stellate capsular and subcapsular cataract. The early changes in the cornea were a similar dust-like pigmentation on the endothelium, progressing to coarse yellowish-white granular deposits in the posterior half of the cornea. Three patients presented the striking, purplish discoloration of the face, neck, and hands. The apparent order of occurrence of change is in the lens first, then in the cornea, and finally in the skin.

Changes in the Cornea and Lens in Patients on Long-Term Chlorpromazine Therapy. George M. Haik, M.D., Luis F. Perez, M.D., and James J. Murtagh, M.D., *South. M.J.*, 59:7, (July) 1966, pp. 839-842



II MJJ

**SURGICAL
GRAND
ROUNDS**

Case Presentation:

Aneurysmosis

EDITED BY JOHN M. BEAL, M.D.

Northwestern University Medical Center

Surgical Grand Rounds are held weekly at 8 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on June 3, 1967.

DR. JAMES SIMONSON: This 64-year-old white male was admitted for the sixth time to Passavant Memorial Hospital for treatment of an asymptomatic left popliteal aneurysm.

His cardiovascular history began in 1951 when he was found to be hypertensive. In 1954 he developed thrombophlebitis of the left leg, for which bilateral saphenous vein ligation was performed. In 1960 deep vein thrombosis was followed by pulmonary embolization which was treated with anti-coagulants from that time until the present. In 1964 his toes became acutely cyanotic. Because of the possibility that this was a reaction to Warfarin, Hedulin was initiated and continued to the present time. In 1962 a diagnosis of gout was made and Benemid was prescribed. In March of 1966 he was admitted to Passavant for the first time for a resection of a right popliteal aneurysm. During this hospitalization an aneurysm of the abdominal aorta and a small aneurysm of the left popliteal artery were demonstrated angiographically. The aortic aneurysm was resected and replaced with a Teflon graft in July of 1966.

Physical Examination: The blood pressure was 140/70 and there were large varicosities of the saphenous system of both legs with hyperpigmentation changes. The peripheral pulses were full and equal. There was an ill-defined pulsatile mass in the left popliteal area.

Laboratory: blood count, urinalysis, fasting blood sugar, blood urea nitrogen, uric acid, and EKG were normal. Prothrombin time was 26 seconds or 19 percent of normal. Bleeding time and coagulation time were normal. Two days after admission a resection of the left popliteal aneurysm was accomplished with a vein graft replacement. The patient had oozing of the blood from the operative site on the fourth post-operative day, at which time his prothrombin time was 32 seconds or 14 percent. Otherwise he made an uneventful post-operative recovery.

DR. JOHN BERGAN: This patient is presented because of the multiplicity of the aneurysms, the problems of approach to their therapy, and the diagnosis of the "Purple Toe" syndrome. This entity is associated with warfarin therapy and is related to dosage¹. (Patient Presented) You recall the episode a number of years ago when your toes were blue. Can you tell us about that incident.

PATIENT: It came on at night like a "Charlie horse" with sharp pain and muscle spasm. Then I noticed tingling in the lower part of my foot. This was a pins and needles sensation. My wife noticed periodic blanching when these spasms would occur and I also saw a marked blanching of the lower leg and upper part of the right foot. The pain persisted during the night, became pretty constant in the foot and lower part of the leg, and then I came to the hospital.

DR. BERGAN: As this is described it is clearly a picture of acute arterial occlusion distal to the knee. Nevertheless, all of the foot pulses were present later when I had the opportunity to examine the patient. The appearance of the foot was that of small blood vessel occlusion in the distal forefoot. There was deep cyanosis of several toes despite normal peripheral pulses. It wasn't until later that it became

obvious that there were a number of aneurysms present and that the "Purple Toe" syndrome was instead a shower of tiny emboli from a proximal aneurysm. (Patient Leaves)

RADIOLOGIST: Dr. Bergan brought the patient to our department and performed a number of studies. This is a left brachial angiogram to demonstrate the aortic aneurysm, which of course was felt clinically. Upon injection of left brachial artery the contrast media demonstrates tortuosity of the thoracic aorta, then the renal arteries are seen to be normal and then the contrast media is diluted with blood and flows very slowly. The aneurysm shows very poorly and is a shadow in this location on these films. Usually the lateral film of the abdomen shows the aneurysm better than any other. In this instance it does not, there being very little calcium in the aorta.

On a separate occasion, femoral angiograms were done. These are selected films from the study and indicate marked tortuosity of the iliac artery on the left during a retrograde injection, and then later on as the serial films are taken one can see the large right popliteal aneurysm and a collection of other aneurysms in the left popliteal system. (Fig. 1)

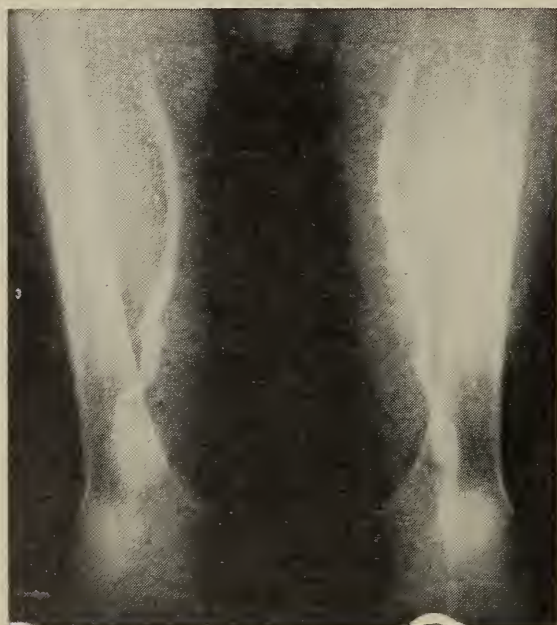


Fig. 1. This radiograph is taken from a series of films exposed after bilateral injection of contrast media into the femoral arteries. The ectatic arterial tree is well seen as are the bilateral popliteal aneurysms. The one on the right is larger but the entire femoropopliteal system on the left is aneurysmal. This indicates the meaning of the term aneurysmosis.

DR. BERGAN: The term "aneurysmosis" I think is a very good term and most descriptive of the patient's condition. As far as I know, it was coined by Dr. Trippel, who putting together two Greek words, aneurysm (dilation) and osis (condition of) described these patients. Actually, they are not at all unusual in a busy practice of vascular surgery. This patient has less aneurysms than the average with this condition. Recently, we collected eight patients who had between them 14 femoral aneurysms. Our focus at that moment was of femoral aneurysms. But in nothing the number of aneurysms these patients possessed, we were startled to find that they had a total of 35 aneurysms in various locations.

This patient had had a history of pulmonary embolization, had been treated by distal vein ligations, and was on chronic anticoagulant therapy. It did not seem wise at any time in his course to withdraw him from anticoagulants. Therefore the aortic aneurysm was resected and the anticoagulant therapy was continued during the surgical event. The aneurysm was clearly below the renal arteries, as it should be. It had two areas of extreme thinning of the wall where it was less than a millimeter in thickness. Of course the inferior mesenteric artery arose from the aneurysm. It was of some interest that the spleen was enlarged. The type of reconstruction was relatively routine with a Teflon Y graft.

The popliteal aneurysm on the right was resected because of the fact that it was large and was symptomatic. The patient had had aching in the calf, and had demonstrated peripheral embolization, which he just now told us about. The aneurysm was resected and the lesser saphenous vein from that location was utilized in the reconstruction. Of course it was reversed.

Similarly on this present admission the remaining popliteal aneurysm was resected and a vein graft used to restore arterial continuity.

Popliteal aneurysms are sometimes a clue to the condition of aneurysmosis. That is, 50 percent of patients who have one will have bilateral popliteal aneurysms, and of those a third will have an aneurysm in another location, such as in the abdominal aorta. This case illustrates this fact.

Popliteal aneurysms can be very complex, as we all know. We as surgeons are aware of the fact that they can either hemorrhage or thrombose. In aneurysms which cross joint creases, thrombosis is more common. Historically these aneurysms have been of great interest to surgeons. We all know about John Hunter's experience. Perhaps less well known is Antonio Scarpa's who treated an aneurysm in the popliteal space by proximal arterial ligation. This aneurysm was as large as the head of an adult.

Some time ago, we recorded our own experience with these very large aneurysms. We called them giant popliteal aneurysms to emphasize that even in this day sometimes they grow to huge size.² It is interesting that Scarpa described his case as being "immense, covered with tense shining skin, being associated with many varicose veins."

This is a venogram in a patient with a popliteal aneurysm. There is an occlusion of the popliteal vein with retention of the contrast media in the venous system. Therefore, patients with this condition can present with primary venous stasis symptoms. Our patient today had such symptoms bilaterally as well as the peripheral embolization phenomenon.

Finally, it is a fact that these aneurysms, unlike aortic aneurysms, are malignant when they are very small. Aortic aneurysms are probably not of great importance in the range of size of 5 to 6 cm., but popliteal aneurysms, even when very tiny, can thrombose and cause the patient to lose his leg. In Gifford's series of 23 patients followed for five years with popliteal aneurysms only five did not lose their limbs because of the aneurysms.³

In summary, this is a patient who presents with a number of aneurysms and who had some unusual problems in management. The basic principle of resection of the aneurysm whenever it occurs and restoration of arterial continuity was followed. It remains the first choice in treatment of this condition.

DR. BEAL: Dr. Trippel, since you coined the term I think you ought to say something about it, and it also seems to me that there must be some problem sometimes in deciding which of these aneurysms you might attack surgically.

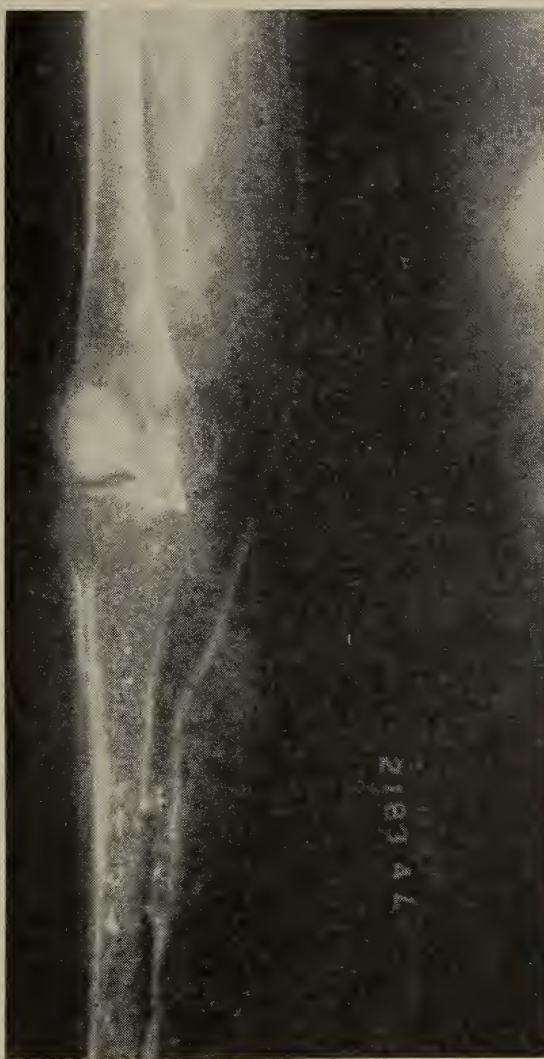


Fig. 2. This phlebogram shows the sharp cut-off of the popliteal vein as it is occluded by pressure from the popliteal aneurysm. The aneurysm itself is made out as a soft tissue density above the knee joint. Distally, one sees the effects of venous stasis and entrapment of contrast media in dilated vein pockets.

DR. OTTO TRIPPEL: Certainly the aneurysms that are symptomatic are ones that require surgery. Similarly, it is an easy decision to make when symptoms and signs of occlusive disease have occurred. Sometimes we simply have to decide on the basis of size. But we haven't actually figured out an arbitrary size as a single indication. I would say that the aneurysm as large as the one we saw today would be resected. Whenever we find a popliteal aneurysm on one side, we automatically shift our hands to the opposite extremity expecting to find a second aneurysm. From there we go to the groin where we often expect the same patient in the distribution already discussed.

Question: What about the carotid artery

aneurysms? Are intracranial or extracranial aneurysms related to this condition?

DR. TRIPPEL: The occurrence of extracranial carotid artery aneurysms is somewhat rare. They are not commonly a part of the aneurysmosis syndrome. Intracranial aneurysms are not of degenerative etiology and are not related.

DR. BEAL: Dr. Bergan, one final question. I noticed in this patient that you used a vein graft in the leg and a Teflon graft in the abdomen. What is the best material for replacing arteries these days?

DR. BERGAN: This management presented today reflects the opinion of people doing vascular repair currently. Plastic prosthetics of either Teflon or Dacron are fine in the abdomen where they are splinted by the spine and where they do not cross joint creases. They will probably last as long as the patient, as long as they don't get infected. But distally, distal to the

groin, autogenous tissue is used. For example, Robert Linton has reported 27 patients who had popliteal aneurysms replaced by vein graft and observed for more than three years.⁴ Only one of the 27 vein grafts failed. None became aneurysmal. The old surgical principle of avoidance of foreign material applies in vascular repair just as it does in hernia repair.

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IT'S THE LAW

Medical books and treatises are not admissible to prove the truth of statements contained therein, the Supreme Court of Washington said. Moreover, even though such writings are admissible to test an expert witness' knowledge, their authoritativeness must first be proved if the witness refuses to concede it.

An article was introduced in a suit by a department store customer for injuries sustained on an escalator in the store. A doctor who testified as an expert witness was cross-examined on an article which appeared in the *Journal of the American Medical Association*, entitled "Survey of One Hundred Cases of Whiplash Injury after Settlement of Litigation." The article indicated that a substantial number of persons having whiplash injuries recovered after the termination of litigation.

In commenting on the article, the court declared that, "it seems to us no more entitled to be called a medical treatise than any other statistical study."

Even assuming the article to be a medical treatise, it was not admissible because it was not established as authoritative, and the doctor had not conceded it to be such. He had testified that he read the article, but he did not concede that he regarded it as other than a statistical study.

The court agreed that an expert should not be permitted to block cross-examination by refusing to concede that a text or treatise is authoritative. However, if he does refuse to concede that point, then the burden of proving that the text or treatise is authoritative is upon the cross-examiner. In this case, the burden was not sustained, the court concluded, since there was no evidence that the views expressed in the article were other than those of an individual doctor, based on a survey made by a senior medical student. Therefore, the jury should have been instructed to disregard that portion of the cross-examination relating to the article, either because it was not a medical treatise or, if it was a medical treatise, because it was not established to be authoritative.

Minnesota Medicine, December, 1966.

A Study of the Effects of Aventyl HCl (nortriptyline hydrochloride) in the Treatment of Patients with Depressive Symptoms

By VLADIMIR L. KOZLOWSKI, M.D., J. R. WILLIAMS, Ph.D.,
AND GABRIEL MISEVIC, M.D./ KANKAKEE

Depressive symptoms comprise one of the most difficult problems in psychiatric practice. Roberts and Miller,⁸ for instance, have mentioned some of the perplexing factors involved, such as (1) the difficulty in recognizing the presence and severity of the condition and (2) the problem of finding a satisfactory treatment for an illness that has such an uncertain course and duration.

The present article deals primarily with the problem of treatment. Psychotherapy is both difficult and dangerous to apply in many cases of depression.^{1,11} With hospitalized patients having histories of suicidal attempts or ruminations, electro-shock treatment has been found to be most effective.⁴ However, there is a great number of depressed patients without suicidal tendencies. Most often they have been treated by the available antidepressant medications. The Monamine Oxidase Inhibitors (MAOI) were frequently used in the treatment of hysterical and atypical depressions.⁸ For the severe endogenous depressions the tricyclics were found to be effective. But the search continues for drugs with special pharmacological qualities that will best fit the individual case of depression.

One of the prime needs in treating depressive symptoms is for a drug that is fast-acting. Aventyl HCl (nortriptyline hydrochloride), a relatively recent antidepressant, has been found effective in treat-

ing depressions within a short period of time.^{3,7,9} The present study was done to test further the effectiveness of this drug.

Methods and Procedures

This study involved a comparison of two groups (experimental and control) of depressed patients, admitted recently to the hospital, to determine any effects of Aventyl HCl in the treatment of the depressive symptoms. The study was conducted over a period of a year and a half, beginning in May, 1965. It was carried out in the Acute Intensive Treatment Service Building where there are three female and two male treatment wards.

The subjects were accumulated gradually from the list of admitted patients routinely worked up for diagnostic purposes. Those patients between 15 and 65, for which this was their first hospitalization, without contraindications from a physical standpoint, and whose diagnosis included the label of "depression" were declared subjects for the study. Altogether 76 individuals (39 experimental and 37 control) became subjects. Of these, 65 subjects (34 experimental and 31 control) remained throughout the period of the study. However, complete data were unable to be obtained in some cases.

All patients were up and about in good general physical condition except for a few with mild generalized arteriosclerotic changes. The patients were clinically

TABLE 1: DESCRIPTION OF SUBJECTS BY TREATMENT GROUPS

Group	# Subjects	Age		Sex		Diagnostic Characteristics	
		Mean	S.D.	Male	Female	Psychotic Depressed	Non-Psychotic Depressed
Experimental	34	36.4	2.7	21	13	26	8
Control	31	38.1	2.2	18	13	16	15

evaluated before starting treatment. Their weight and blood pressure were recorded, as well as their complete blood count, hemoglobin, hematocrit, and urinalysis. Results of physical examinations and laboratory findings were within normal limits before treatment was initiated.

By procedures worked out ahead-of-time, the subjects were randomly assigned to separate groups and these in turn to the two treatment methods. A description of the subjects by treatment groups is shown in Table 1.

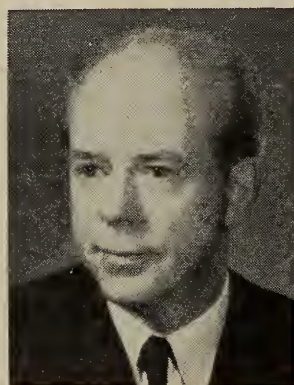
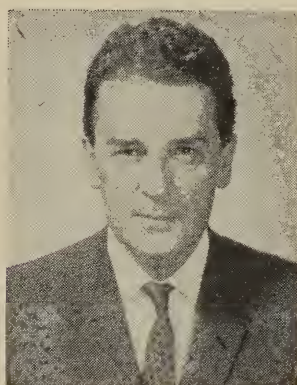
The experimental and control groups were exposed as nearly as possible to the same conditions (ward activities and off-ward recreational and occupational pursuits) except for the treatment variable. The difference in treatment was that the subjects in the experimental group were administered Aventyl HCl, while the subjects of the control group were given a placebo (substance of identical color and shape), using the same manner of administration in the two groups. With the exception of eight cases, the Aventyl HCl was administered in doses of 25 mg. three times per day. In the eight cases it was administered four times a day. All personnel on the treatment wards were unaware whether a subject was a member of the experimental or control group.

Thirty days was considered the length of treatment time for all subjects. The

subjects were evaluated shortly before and soon after (and in a few cases near the midpoint of) this treatment period. Test scores, behavior ratings, and clinical judgments were used in the various evaluations. Tests employed were portions of the Wechsler Adult Intelligence Scale and the complete Cattell² 16 Personality Factor Test. The Wittenborn¹⁰ Psychiatric Rating Scale was used to get ratings of subject behavior. Four sub-tests of the Wechsler were used, namely: Vocabulary, Arithmetic, Block Design, and Digit Symbol. The 16 P.F. "A" and "I" scores were "second order" factor scores thought to indicate "anxiety" and "introversion" tendencies. Factor IV of the Wittenborn referred to "Depressed State" and Factors I and V to "Acute Anxiety" and "Schizophrenic Excitement" respectively. The clinical judgments were arrived at through observation of the subjects as well as examination of the daily behavior charts and progress notes. Clerical people in the Psychology Department, Nurses and Aides on the wards, and the ward Physician assisted in obtaining the respective types of data.

Results

The results in terms of the test scores and behavior ratings for the groups as a whole are shown in Table 2. Here it can be seen that in the case of both groups and for every test and rating factor or trait



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TABLE 2: MEAN AND STANDARD DEVIATION OF PRE- AND POST-TEST SCORES AND BEHAVIOR RATINGS

Group	Pre-Scores								Post-Scores							
	16 P.F. *				Wittenborn +				16 P.F.				Wittenborn			
	"A"		"I"		Factor IV		Sum I, IV&V		"A"		"I"		Factor IV		Sum I, IV&V	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Experimental	9.25	1.38	8.80	1.37	3.98	1.14	3.52	1.40	8.35	1.11	7.22	.61	3.50	1.09	2.79	1.03
Control	8.25	1.70	8.32	.81	3.86	1.87	2.93	1.48	7.65	1.91	7.27	.49	2.43	1.05	1.80	.52

* N=15

+ N=24

used there was a decrease in score between the pre- and post-evaluating points. Since lower scores were meant to signify a smaller amount or display of the symptom, it may be stated that the results showed some degree of improvement. Although not shown in the table, the mental functioning of the two groups, as measured by the Wechsler Test, also improved. In this case the post-test scores were higher for both groups and for both verbal and non-verbal functions.

The evaluation of these score changes is given in Table 3. A negative net shift in scores meant the experimental subjects "improved" more, whereas a positive net shift indicated greater "improvement" in the control subjects. It can be seen that the net shift in test scores in both cases favored the subjects in the experimental (Aventyl HCl-treated) group but that the net shift in behavior ratings in both cases showed the control (placebo-treated) subjects to have done better. The largest net shift occurred with the control subjects in the case of the factor of "Depressed State," but the "t" value of this shift is significant at only the 13 percent level. The next largest shift took place with the experimental subjects and involved the factor of "Introversion," significant at only 19 percent level. In other words, the probabilities that these two net shifts are due

to chance (rather than to the differential effects of the treatments) are approximately 13 and 19 out of 100 respectively.

Clinical judgments of change between the two groups appear in Table 4 where four categories of "judged improvement" are indicated. It can be seen that 76.5 percent of the experimental subjects were judged as "improved," whereas only 51.6 percent of the control subjects were so judged. Using the "t" test for evaluating differences in proportions, as given by McNemar,⁶ the obtained difference in this case is significant at the 2 percent level. The probability of a difference this large being due to chance is approximately two chances out of 100. However, further evaluation of these clinical judgments of change, making use of all 4 categories, revealed less significant results. The categories contained in columns 1 and 2 were combined to form an "improved" category and those in columns 3 and 4 to make an "unimproved" category. With use of "Yates Correction" for limited values in the cells, as given by Koenker,⁵ a X^2 (chi-square) value of 1.84 ($P > .15$) was obtained.

Finally, in Table 5 are represented the changes in the two groups as related to the subject variables of sex and psychiatric condition. A study of the table will reveal that, of all 32 pairs of pre- and post-evalua-

TABLE 3. EVALUATION OF TEST-SCORE AND BEHAVIOR RATING CHANGES BETWEEN EXPERIMENTAL AND CONTROL GROUPS

Area of Change	Net Shift in Scores		t	P (To nearest hundredth)
	(Experimental Group Change)	— (Control Group Change)		
16 P.F. Test Scores				
"A"	(- .90)	— (- .60) = -.30	.51	.30
"I"	(-1.58)	— (-1.05) = -.53	.87	.19
Wittenborn Psychiatric Rating Scale Scores				
Factor IV	(- .48)	— (-1.43) = +.95	1.14	.13
Sum of Factors I, IV, & V	(- .73)	— (-1.13) = +.40	.80	.21

TABLE 4: CLINICAL JUDGMENTS OF CHANGE BETWEEN THE TWO GROUPS

Group	# Judged Improved	# Judged Slightly Improved	# Judged Questionably Improved	# Judged Unimproved
Experimental	26 (76.5%)*	2	0	6
Control	16 (51.6%)	4	2	9

* $t = 2.09$

P = .02 (One-tailed Test)

tions involving the 16 P.F. and Wittenborn scores, in only one pair is there an increase in score or an indication of patients getting worse. This involves the experimental, female subjects on the Wittenborn factor of "Depressed State." Also, it may be noted that with respect to clinical judgments only the female controls and psychotic controls, as groups, contained as many subjects "judged unimproved" as "judged improved."

Comment

This study showed, first of all, that hospitalized subjects with depressive symptoms, whether treated with Aventyl HCl or with a placebo, tended to "improve" over a period of approximately 35 days. This was expected and requires no particular explanation here.

There were, however, differences in the pattern of improvement as determined by the different approaches to evaluation used. The superiority of the Aventyl HCl treated group over the control group appeared in the patients' assessment of themselves on the 16 P.F. test and in the clinical judgments of their conditions by impartial medical staff members. The superiority of the control group came out in the Wittenborn ratings given by the nurses and aides. These differences could have been due to (1) actual evaluative errors (2) the difference in things being evaluated by the three evaluative approaches and (3) the fact that no two of the approaches encompassed the same group of subjects. The available evidence indicates that (3) was the primary reason, with (2) partially responsible and (1) probably not involved. This conclusion stems mostly from a comparison of how each of the approaches evaluated the same subjects. For example, of the 12 subjects showing im-

provement on one or both factors of the 16 P.F., 8 were judged by the medical staff as "improved," one as "some improved," 2 as "questionably improved," and one as "unimproved." Likewise, of the 20 subjects rated improved on the Wittenborn scale, 14 were judged as "improved," 3 as "some improved," one as "questionably improved," and 2 as "unimproved." Also, of the 6 subjects with results from both 16 P.F. and Wittenborn scale, 5 were in agreement on the direction of patient change during the treatment period.

The other finding bearing on the question of differences in results is the fact that the split-half reliability of the Wittenborn ratings in the present study was .774, comparable to that listed by the author in the test manual. Therefore, in view of the fairly close agreement among the three approaches in evaluation of specific cases plus the established reliability of the ratings, the main reason for the obtained differences seems to be that each was evaluating a somewhat different group of subjects.

A few remarks remain about individual patient response to the Aventyl HCl treatment. As mentioned earlier, the selected patients had symptoms of depression and were treated without regard to diagnosis. However, the most impressive results in alleviation of depression and lessening of anxiety were noted among the patients suffering from psychoneurotic depressive reactions, psychotic depressive reaction, and especially involutional psychotic reaction. It was noted that agitated and depressed patients benefited from Aventyl HCl and that a definitely stimulating effect was produced in withdrawn, depressed, and akinetic patients. It is probably worth noting here that four of the six experimental subjects judged "unimproved" carried a primary diagnosis of schizophrenia and

TABLE 5: CHANGES IN THE TWO GROUPS AS RELATED TO SUBJECT VARIABLES

Group	16 P.F. Scores					Wittenborn Scores		Clinical Judgments		
	Mean Pre "A"	Mean Post "A"	Mean Pre "T"	Mean Post "T"	Mean Pre IV	Mean Post IV	Mean Pre I, IV, V	Mean Post I, IV, V	# Judged Im- proved	# Judged Un- improved
<i>Experimental</i>										
Male	8.81	8.21	8.33	6.30	3.86	2.57	3.46	2.23	16	3
Female	9.08	8.27	8.12	6.75	3.58	3.75	3.42	3.08	10	3
Psychotic	8.63	8.19	8.02	7.06	3.77	3.50	3.55	2.73	18	6
Non-Psychotic	9.70	8.41	8.87	7.25	3.62	2.50	3.20	1.87	8	0
<i>Control</i>										
Male	9.51	8.63	8.50	7.65	3.16	2.25	2.66	1.70	12	5
Female	7.77	6.08	7.87	6.87	3.90	2.10	3.08	1.78	4	4
Psychotic	8.22	7.17	8.14	7.31	3.75	2.25	3.11	1.77	7	7
Non-Psychotic	9.05	8.89	8.08	7.58	2.83	2.00	2.17	1.67	9	2

that the other two were in the general category of "psychotic depressed."

It is also noteworthy that no significant changes in patients' physical condition nor in laboratory findings attributable to the Aventyl HCl treatment occurred. Not a single side effect of importance was observed.

Summary

The present "double-blind" study involved 65 subjects with depressive symptoms and hospitalized for the first time. The experimental group of 34 was treated for 30 days with Aventyl HCl, while the control group was administered a placebo. Pre- and post-evaluations, involving questionnaire, behavior rating scale, and Clinical judgment were carried out, although not on the same number of subjects.

Overall results showed that the subjects in both groups tended to improve, but there was some degree of difference in the relative amounts of improvement in the two groups as determined by the three evaluative approaches. Patient self-evaluations and clinical judgments of change favored the experimental group, whereas ratings by the nurses and aides gave the advantage to the control group. All differences between the groups were significant at only 10-20% level, approximately. What, at first, seemed like true differences in the results from the three approaches turned out on further examination and comparison to be largely due to the fact that the same group of subjects was not being evaluated in each case.

With regard to individual patient response to Aventyl HCl it was generally

observed that the greatest relief of depressive symptoms occurred in those with psychoneurotic, involuntal, and psychotic depressive reactions. On the other hand, the severely depressed and the severely schizophrenic patients did not improve. No important side effects nor change in physical condition of patients due to the treatment were observed.

Acknowledgments

The authors hereby gratefully acknowledge the assistance of physicians, nurses, and aides on the Acute Intensive Treatment Service and of members of the Psychology Department in the planning and execution of this study.

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A Face Saving Procedure: Marginal Resection of the Mandible for Anterior Oral Cancer

By MYLES P. CUNNINGHAM, M.D., AND DANELY P. SLAUGHTER, M.D. / EVANSTON

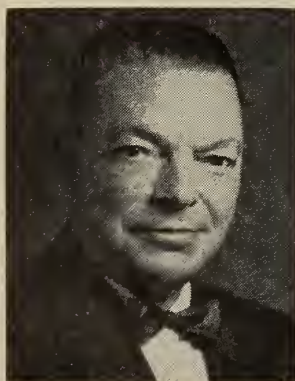
Radical surgery for cancer of the head and neck still tends to frighten and dismay both patients and physicians. Not only is there a frequent sense of futility about prognosis but a natural concern for the patient's subsequent appearance often influences responsible physicians to refer patients for radiation therapy or chemotherapy on the mistaken notion that these are "kinder" or "less mutilating" forms of treatment. While radiation therapy (and to a much lesser extent chemotherapy) has an established place in the treatment of certain areas and stages of head and neck cancer, surgery remains the fundamental approach to these tumors.

Cancer of the tongue, cheek mucosa, floor of mouth and gingiva is especially distressing when it involves the mandible and poses major problems for subsequent functional and cosmetic rehabilitation if the arch of the mandible must be sacrificed. This procedure, which creates the so called "ANDY GUMP" deformity, is extremely disabling for both speech and deglutition and has occasioned many modifications in closure and

attempts at arch prosthesis.¹⁻³ At best these are only partially satisfactory.

Whereas resection of the arch or other whole segments of the mandible is occasionally obligatory, frequently a modification of the excision with virtually no cosmetic or functional deformity is possible. This procedure, known as marginal resection of the mandible, is well accepted by experienced head and neck surgeons and is technically reasonably simple. It depends largely for its success upon proper selection of patients. If the adjacent soft tissue cancer has invaded deeply into bone or involves the mental foramen or the medullary cavity, then full thickness excision of bone must be performed. If, however, the tumor is merely attached to or adjacent to bone, marginal excision will be entirely adequate. It is a serious error merely to separate the soft tissue cancer from the surface of the bone to which it is attached simply because a "plane of dissection" seems to present itself. Periosteal involvement by cancer demands

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an adequate bony margin to minimize chances of local recurrence.

The technique of marginal resection, basically quite simple, will most often be part of a composite operation that includes neck dissection. When the neck dissection has been completed, and with the specimen still attached, a line of excision in the mandible providing adequate margins around the cancer is exposed. Employing a Stryker saw the bone is divided through both inner and outer tables making first the horizontal and subsequently the vertical cuts (Fig. 1). Care must be taken when making the vertical cut not to fracture the mandible but should this occur, repair can usually be accomplished by wiring the fracture ends through two small drill holes.

In planning the excision as part of a block resection of neck, jaw and intraoral primary, it is wise to perform the bony excision prior to excising the primary cancer in the mouth. It may otherwise be awkward to control hemostasis in the muscles in the floor of the

mouth until the bone has been removed, whereas with the bony margins circumscribed, the floor of mouth or gingival tissues can be dissected with dispatch and with minimal loss of blood.

Oblique cuts (Fig. 2) through the mandible can be fashioned to remove either the inner or outer tables and still preserve a strut of bone. The procedure is appropriate for both upper and lower edges of the mandible (Figs. 2, 3) or for any length of the horizontal ramus. Upper marginal resection will be employed for overlying and attached gingival and floor of mouth cancer (Fig. 2) while lower marginal resection is often required during the course of a neck dissection to gain an adequate margin around upper cervical lymph nodes harboring metastatic cancer that are attached to the mandible (Fig. 3). Figures 4 and 5 illustrate the usefulness of the technique in two fairly typical cancers of the anterior oral cavity.

(Text Continued on page 179)

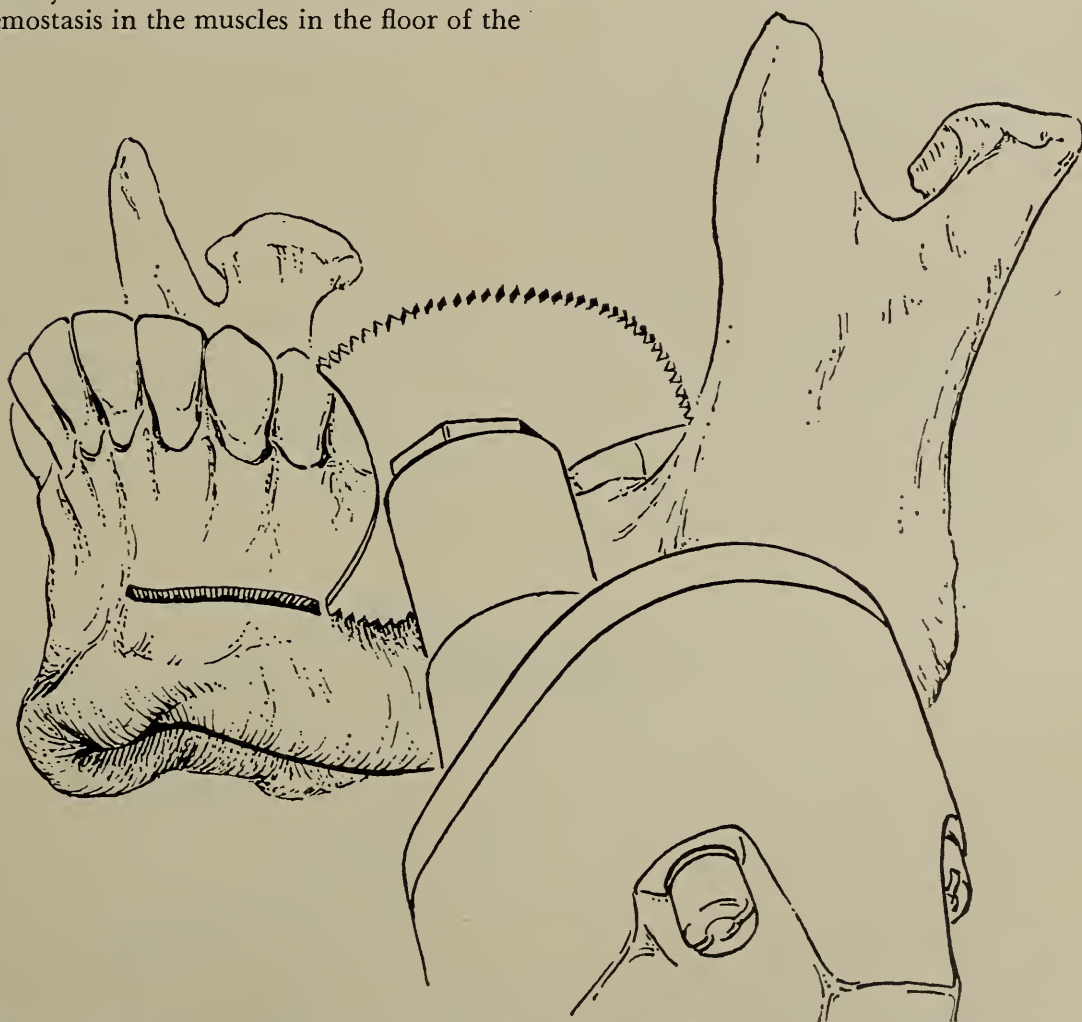


Fig. 1. Diagrammatic representation of use of Stryker saw to obtain precise division of mandible.

Cancer of the gingiva
(not invading bone)

Fig. 2. The approximate margin one might anticipate for a hypothetical cancer of the gingiva (ef. Fig. 4). Oblique cuts permit a wider margin of bone to be excised from either upper or lower margin of the mandible.

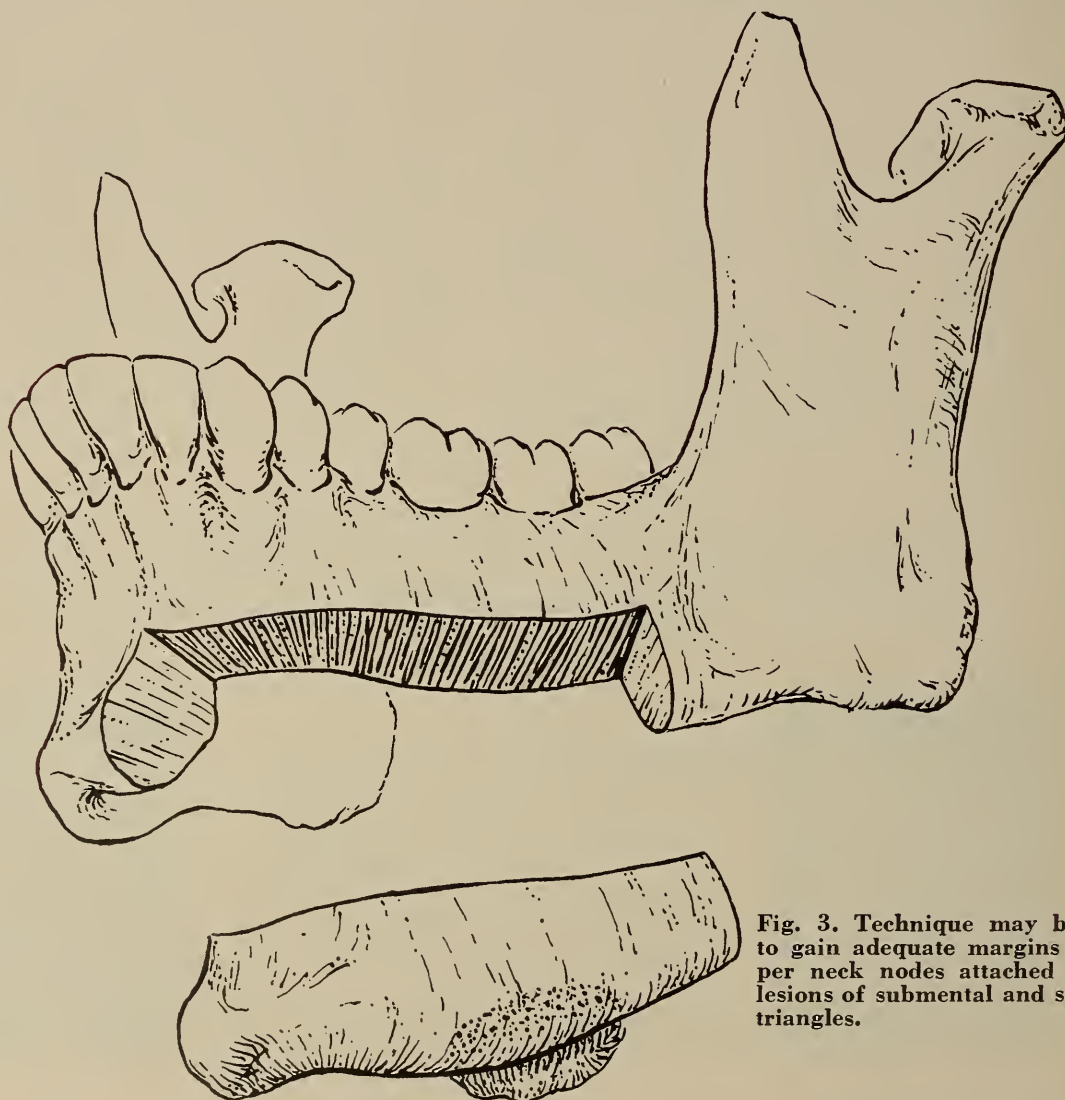


Fig. 3. Technique may be employed to gain adequate margins around upper neck nodes attached to bone or lesions of submental and submaxillary triangles.

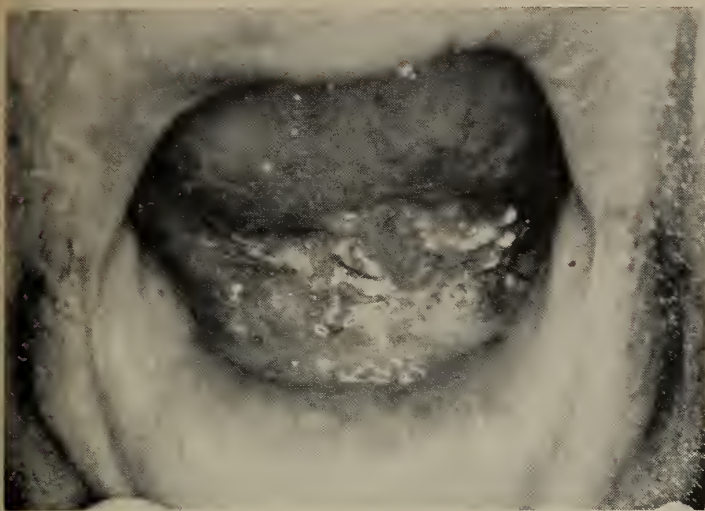


Fig. 4A Extensive, ulcerating epidermoid carcinoma of anterior floor of mouth.

Fig. 4B One month following a monobloc excision including neck dissection, marginal resection of mandible, and excision of floor of mouth, patient has facial symmetry and satisfactory speech and swallowing.

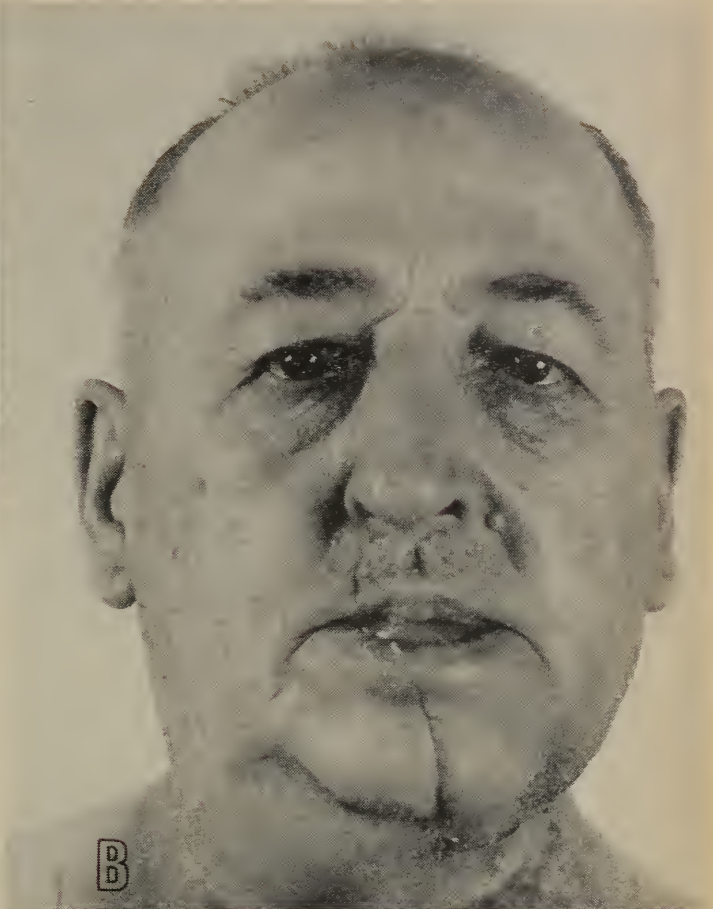
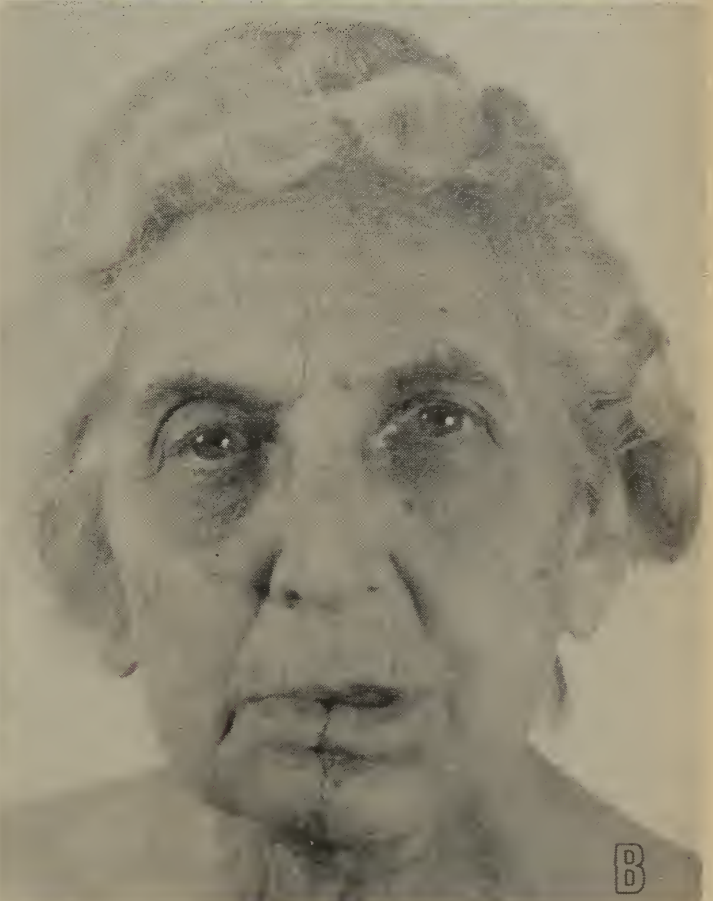
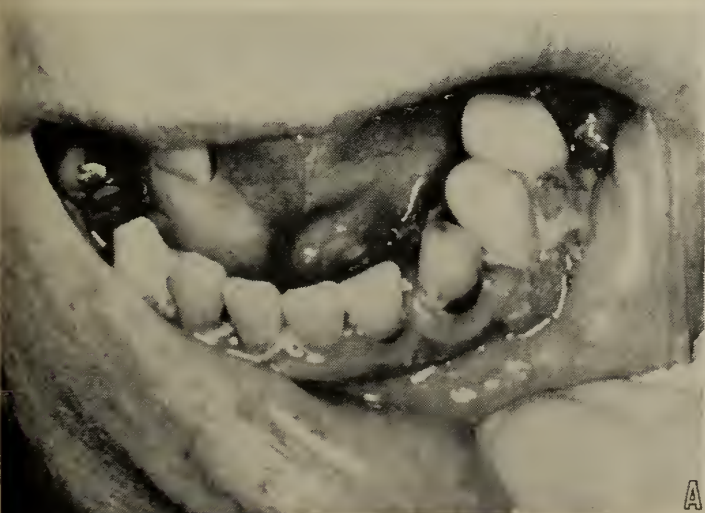


Fig. 5A Epidermoid cancer of the gingiva with metastases to upper cervical nodes in an eighty-two year old woman.

Fig. 5B Six weeks after surgery including neck dissection, marginal resection of the mandible and excision of gingiva, the mandibular arch is intact and patient's speech and swallowing are virtually normal. While age itself is no barrier to radical surgery, rehabilitation following loss of the mandibular arch in elderly individuals may be impossible.



Amniocentesis and Amniotic Fluid Analysis in Clinical Obstetrics

By ROY M. PITKIN, M.D. / CHICAGO

Though the mechanism of formation of amniotic fluid is not precisely known, it is probably in part of fetal origin and might therefore be expected to reflect the fetal condition. Transabdominal aspiration and analysis of the amniotic fluid is one of the most significant recent developments in clinical obstetrics. Over the course of the last five years, it has become established as an integral part of the management of one complication of pregnancy and its use has been suggested in several others.

This paper will review the technic of amniocentesis, some of the clinical situations in which it may be helpful, and the actual or potential hazards of the procedure.

TECHNIC

Amniocentesis is a relatively simple procedure usually done in the out-patient clinic. Premedication is unnecessary. After the patient voids the abdomen is carefully palpated to outline the fetus. In selecting the site for amniocentesis (Fig. 1), the most inferior area in which a sensation of fluid can be palpated is preferable, since this lessens the chance of puncturing the placenta. If there is difficulty in outlining the fetus in the lower uterine segment, the area of the fetal small parts may be selected.

The operator wears sterile gloves and the area around the site selected is painted with an antiseptic solution. If desired, the skin

may be infiltrated with a local anesthetic agent. A 22-gauge spinal needle is inserted through the abdominal wall. While the needle is advanced, the patient will frequently complain of a mild twinge of discomfort as the parietal peritoneum is pierced. With further advancement there is continued resistance followed by a rather sudden loss of resistance as the needle enters the amniotic sac. When the stylus is withdrawn, fluid will well up in the needle. A syringe may be used to aspirate the appropriate amount of fluid, after which the needle is swiftly withdrawn.

If spectrophotometric or chemical analysis is to be carried out, it is advisable to centrifuge and filter the fluid as soon as possible. In addition, if the indication for amniocentesis is suspected erythroblastosis, the fluid should be protected from light until analysis.

No particular precautions are necessary after the procedure and the patient may be allowed to return home immediately.

CLINICAL USES

Rh isoimmunization

Prior to advent of amniotic fluid analysis, the management of pregnancies complicated by Rh isoimmunization depended on the obstetrical history and the maternal antibody titer and resulted in a rather wide margin of error in a number of instances.



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It had been observed for many years that the amniotic fluid in severe erythroblastosis fetalis was frequently yellow in color. Bevis¹ showed that this discoloration was due to various blood pigments and that lesser amounts, not visible to the naked eye, were found with milder forms of the disease. Both Liley² and Walker³, in studying amniotic fluid in erythroblastosis, found that spectrophotometric scanning was a simple and accurate method of diagnostic and prognostic significance. In normal pregnancy the absorption curve of amniotic fluid from 350 to 650 millimicrons is relatively linear. If the fetus is afflicted with hemolytic disease, however, there is increased absorption at 450 millimicrons. The substance responsible for this increased absorption is not precisely known but it is probably bilirubin alone or in combination with other similar blood pigments. In any event, the extent to which spectral absorption at 450 millimeters deviates from the normal curve is proportional to the degree of fetal disease.

In the management of the pregnant Rh negative woman, the first step is the indirect Coombs test and antibody titers. If these are negative, nothing else need be done except to repeat them in late pregnancy. If they are positive, and particularly if they are positive in a titer of 1:8 or greater, the next step is amniocentesis. We usually do amniocentesis in the Rh sensitized patient at 24 to 26 weeks gestation. Of the several methods devised for grading the degree of abnormality in absorption at 450 millimicrons we have found Freda's⁴ to be most useful. If the scan is negative or 1+ abnormal, we repeat the study at two to three week intervals. If a 2+ abnormality is found we repeat it in one to two weeks. A 3+ or 4+ abnormality is evidence of severe disease for which preterm or premature delivery or, in the case of marked prematurity, intrauterine fetal transfusion is indicated.

Fetal maturity

Termination of pregnancy is an important part of the management of a number of obstetric complications such as toxemia, diabetes, erythroblastosis, and placenta previa. Timing of termination of pregnancy frequently depends to varying degrees on an estimation of the maturity of the fetus. Several changes have been proposed for use in estimating fetal maturity, though none has yet received widespread clinical acceptance.

There is a progressive increase in the albumin-globulin ratio of amniotic fluid protein in late pregnancy and Heron⁵ suggested this change as a method of determining intrauterine fetal age. Brosens and Gordon⁶ studied the cytologic characteristics of the fetal epithelial cells when stained with Nile blue and found that the percentage of orange-stained cells increased progressively from 36 weeks to term. We have been particularly interested in the creatinine concentration in amniotic fluid⁷. In our experience with approximately 250 patients, creatinine level of 2 milligrams per cent or greater (with normal maternal serum creatinine) is invariably associated with a fetus weighing 2500 grams or more while one of less than 2 milligrams per cent is associated with prematurity in at least 95 per cent of instances.

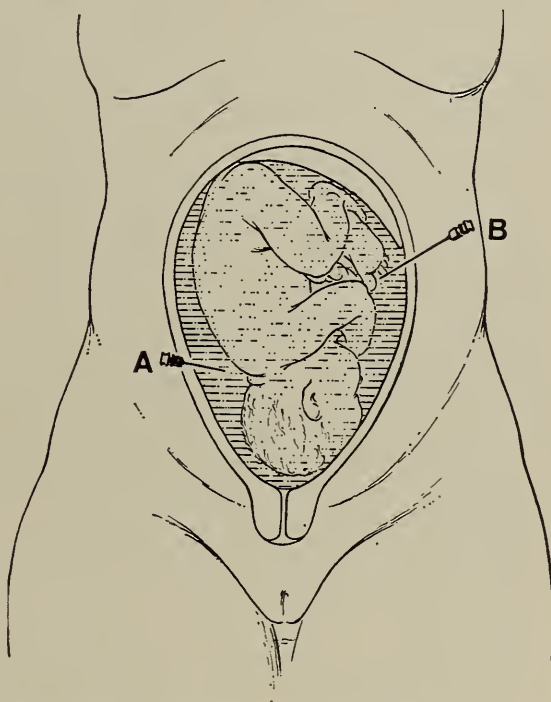


Fig. 1: Sites for amniocentesis (A) Posterior to the fetal neck. (B) In the area of the fetal small parts.

The question of postmaturity is frequently raised. Considerable controversy exists as to the nature of the "postmaturity syndrome" or, indeed, as to whether such an entity exists. However, if amniocentesis in a patient suspected of having postmaturity yields an abundant flow of unstained amniotic fluid, one may be assured that the fetus has not come to harm.

Fetal sex

The number of apocryphal methods purported to determine the sex of an unborn

child attests to man's preoccupation with this problem throughout the ages. With the description of the sex chromatin body in the nucleus of genetic females, a method with scientific merit became possible. Since the amniotic fluid contains epithelial cells shed from the fetal skin, microscopic examination of properly stained sediment permits prenatal determination of the fetal sex with a high degree of accuracy⁸. However, this information is sought only in instances in which it is important, such as where an hereditary sex-linked disorder is suspected. Its use simply to satisfy curiosity is not recommended and, in view of the small but definite risk of amniocentesis, it is doubtful if it ever will be.

Other conditions

Occasionally, the question of intrauterine fetal death cannot be answered by any of the usual means. In such instances the appearance of the amniotic fluid is often helpful. It is thick and deeply meconium-stained when the fetus has been dead for any length of time.

The prenatal diagnosis of adrenogenital syndrome by the finding of high levels of 17 keto-steroids in the amniotic fluid was recently reported⁹.

HAZARDS

Maternal injury

The maternal risk with amniocentesis appears to be minimal. Though perforation of bowel or bladder is a theoretical hazard, it has not been reported. Laceration of a maternal vessel on the pregnant uterus also seems to be extremely rare. In a series of patients who had amniocentesis with a large bore needle prior to cesarean section, we have found great difficulty in even locating the uterine puncture site with the abdomen open one hour later.

Fetal injury

Direct injury to the fetus also appears to be more of a theoretical than a practical risk. Though it probably occurs on occasion, untoward results are very infrequent. In performing intrauterine transfusions, injection of radiopaque material sometimes indicates that the needle has penetrated the chest, liver, or bladder, but serious sequelae are rarely encountered. In spite of this, every effort should be made to avoid fetal injury. Displacement of the fetus by the operator's hand away from the site of amniocentesis is frequently helpful in this regard.

Transplacental hemorrhage

There is good evidence that disruption of the placental vascular system with amniocentesis may cause fetomaternal bleeding and, if the fetal blood loss is extensive, exsanguination may result. Such occurrences are apparently rare, though several instances of large transplacental hemorrhages with resultant fetal anemia and hypovolemia have been reported¹⁰⁻¹². However, even minimal degrees of fetomaternal hemorrhage may pose a distinct immunological hazard in the Rh negative woman. Significant rises in antibody titers have been reported in a high percentage of Rh sensitized patients in which amniocentesis was either unsuccessful or yielded fetal blood^{12, 13}. On the other hand, the percentage of patients showing significant rises in antibody titers during pregnancies in which amniocentesis was performed is no higher than that in which amniocentesis was not done¹⁴. Thus, while the evidence is not yet conclusive, amniocentesis must be considered at least a potential immunizing hazard and for this reason it should be avoided in the Rh negative unsensitized woman.

In order to avoid these dangers of placental puncture, routine radioisotopic localization of the placenta prior to amniocentesis has been advocated¹⁵. We have not felt that this is necessary in most instances and in our experience with approximately 300 amniocenteses have had no cause to regret failure to do it. The incidence of "bloody taps" may be kept at a minimum by carefully determining the fetal position, performing amniocentesis in one of the two sites indicated, and using a fine gauge needle. If gross blood is aspirated, it should be analyzed to determine whether it is maternal or fetal. If it is fetal, the physician should carefully monitor the fetal heart for the next 6 to 12 hours and be prepared to treat anemia and hypovolemia when the infant is born.

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(Continued on page 196)

Erythema Nodosum As a Manifestation of Ulcerative Colitis

By OSCAR A. NOVICK, M.D., AND HOWARD S. TRAISMAN, M.D. / CHICAGO

With advancing knowledge of the pathophysiology of various disease states, dermatological manifestations have been correlated with a wide variety of disease entities involving various organ systems of the body. Many of these cutaneous signs are subtle in nature. Erythema nodosum, however, constitutes a dramatic clinical episode. Fever, painful tender nodules on the anterior aspects of the legs, ankles and occasionally the arms present a typical picture. The associated arthralgia, while acute and painful, is of secondary importance to the cutaneous lesions and the systemic manifestations. There should be little difficulty in recognizing this entity as it represents a distinctive physical sign and should alert the physician to a number of important diseases.

Careful search will often disclose some underlying process, the significance of which may be eclipsed while the erythema nodosum runs its course. This is especially true in the pediatric age group where a variety of underlying disorders such as an adverse drug reaction, or an infectious process may be overlooked.

Erythema nodosum may represent a rare extra-colonic manifestation of ulcerative colitis in children. To illustrate that the diagnosis of ulcerative colitis may often be difficult to make in children, a case of erythema nodosum as an early manifestation of ulcerative colitis is presented in a juvenile diabetic. While there is no known association between ulcerative colitis and diabetes mellitus, the case is presented to illustrate that a careful investigation should be instituted in every instance of erythema nodosum, despite the fact that there is a pre-existing disease.

Case History

P.G., a 15-year-old white female of Jewish extraction was admitted to this hospital on Oct. 11, 1965, for the 23rd time. Her previous 22 admissions were because of ketoacidosis or hypoglycemic reactions. There are many emotional problems aggravated by an unsatisfactory home situation.

Two weeks prior to her present admission the child developed a non-specific gastroenteritis which lasted for three days. Ten

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days prior to admission she developed what was at first believed to be a cellulitis of both legs. In light of her diabetic history she was started on appropriate doses of penicillin and sulfa. However, little if any improvement was noted and at admission irregularly shaped, red, raised, and painful lesions limited to the anterior portions of both lower extremities were present.

Physical examination revealed a 15-year-old adolescent, uncomfortable, toxic appearing and barely able to walk. Her temperature was 101°F., pulse 110/, and respirations 22/minute. Positive clinical findings were limited to the red raised nodules varying in size from 2-10 cm. in diameter over both legs. Some of the lesions were violaceous, but all were warm and very tender to the touch.

The hemoglobin on admission was 9.2 gm./100 ml., hematocrit 32 percent, the white blood cell count was 15,600 with a normal differential. Urinalysis was normal. The fasting blood glucose was 185 mg percent, the blood urea nitrogen 9 mg./100 ml., her serology was negative. ASO and CRP within limits of normal. Protein electrophoresis revealed an albumin of 2.93 gm. percent, alpha-1: 0.81 gm. percent; alpha-2: 0.71 gm. percent; beta: 0.6 gm. percent and gamma globulin of 1.16 gm. percent. Throat and stool cultures grew normal flora. Ova and parasites were not found in the stools. Stools were soft, mushy and brown with 3-4 being passed per day. Two-plus occult blood was present. Intermediate tuberculin, histoplasmosis, coccidio—and blastomycosis skin tests were negative. Chest x-ray was normal.

Proctoscopic examination revealed a friable, hyperemic mucous membrane with several areas of superficial ulcerations of the mucosa being present. Barium enema revealed a definite picket-fence appearance of the descending colon with early involvement of the transverse colon as well.

A bland low-residue diet was prescribed in keeping with her weighed diabetic diet, Azulfidine (azosulfapyridine), 1 gm. q.i.d.; Valpin (anisotropine methylbromide), one tablet q.i.d.; multiple vitamins; and Fergon (ferrous gluconate) 0.3 gm. t.i.d. was instituted. With this regime she showed marked improvement. The stools became less frequent and more formed in nature. Her insulin requirements dropped from 38 units of regular and 78 units of Lente in-

sulin on admission to 20 units of regular and 58 units of Lente insulin per day. After three weeks, she was discharged with a five-pound weight gain.

One year later she shows no recrudescence of her disease and in fact is constipated. Repeat proctoscopic and barium enema studies were normal.

Discussion

Erythema nodosum is a distinctive, easily recognized cutaneous lesion which involves the corium and deeper tissues. The skin lesions may enlarge from a pea-sized nodule to that of a half-dollar. The various sized subcutaneous nodules are discrete, indurated, and exceedingly painful to touch. The lesions are usually symmetrical and are usually limited to the pre-tibial areas but may also involve the scalp, face, neck, ulnar aspects of the arms, trunk, buttocks, thighs, calves, and feet. The eruption begins as an erythematous nodule and proceeds through a kaleidoscopic array of red, blue and yellow color changes.

At first appearance, constitutional signs and symptoms related to the background infection, are the rule. The clinical picture which is accompanied by a fever of 102-104°F., ill-defined joint pains and feelings of discomfort in the extremities appears suddenly and may be full blown within 12-24 hours. There is nothing constant or characteristic about the prodrome.

Erythema nodosum is accompanied by an elevated sedimentation rate. The white count may be normal or elevated depending upon the underlying cause of the syndrome. There is usually a concomitant anemia, eosinophilia is an inconstant finding, and the albumin-globulin ratio is reversed with a hypergammaglobulinemia being present.

The eruption is rarely seen during the first two-three years of life. Boys and girls are equally affected until puberty but thereafter, it is much more frequent in females than males. Erythema nodosum shows a seasonal incidence with its peak occurrence during the winter months. In a review of 155 cases, Favour and Sosman² found that upper respiratory infections preceded the onset of the syndrome in over 80 percent of their patients; 50 percent of these had pharyngitis caused by the beta-hemolytic, group A streptococcus.

On occasion, because of the fever, joint pain and elevated sedimentation rate, erythema nodosum may be difficult to differ-

entiate from rheumatic fever. Although streptococcal infections have been implicated as a possible cause of erythema nodosum, no correlation has been found between the antistreptolysin titers and the syndrome. Occasional false positive serological tests have also been reported.

At one time, erythema nodosum was considered to be a disease *sui generis*, but this is no longer true. It has been implicated in a variety of internal disorders representing an important clue in the diagnosis of serious systemic disease. An underlying cause for erythema nodosum may be demonstrated in 50-75 percent of the cases. For many years it was considered to be a rare "id-like" reaction to the tubercle bacillus or as a result of streptococcal infections.

In light of more recent knowledge erythema nodosum may accompany a variety of other bacterial, viral or fungal infections (Table I). However, the lesions of the erythema nodosum are not characterized by the presence of the causative agent and their morphological characteristics do not resemble that of infection.

Erythema nodosum represents a hypersensitivity vasculitis resembling the lesion of polyarteritis nodosa. Involvement of the small blood vessels is a constant accompaniment with thickening and infiltration of their walls. Inflammation, vascular engorgement

and perivascular cellular infiltration consisting of polymorphonuclear leucocytes, lymphocytes, plasma cells and eosinophils are seen. The surrounding collagenous tissue is edematous. Immunological mechanisms producing hypersensitivity reactions to bacterial antigens, drugs, or other provocative agents have been proposed for the pathogenesis of erythema nodosum, but establishment of this proposal has not been possible. Nevertheless, the morphological resemblance of the lesion of the erythema nodosum to the vasculitis characteristics of the Arthus phenomenon suggests that immunological processes are important. The fact that manifestations of systemic vasculitis often occur or persists further suggests that after a single initiating allergic event an inherent susceptibility exists which becomes clinically manifest only after a triggering event.

The association of erythema nodosum with ulcerative colitis was first described by Brooke in 1933. The reason for the coexistence of erythema nodosum and ulcerative colitis is unknown, but in both diseases there is an underlying micro-vasculitis; this may be due to the fact that patients with ulcerative colitis have been found to have circulating autoantibodies directed against colonic mucosa, and one might speculate on the possible cross reactivity of these anti-

Table I
Possible Underlying Causes for Erythema Nodosum

A. INFECTIOUS		
I. BACTERIAL		
Streptococcal		
Meningococcal		
Pertussis		
IV. VENEREAL		
Lues		
Gonorrhea		
Lymphogranuloma		
Venereum		
B. TOXIC ALLERGIC		
Ulcerative Colitis		
Loeffler's Pneumonia		
Dental Caries		
C. DRUG INDUCED		
Sulfonamides		
Iodides		
Bromides		
Salicylic Acid		
Phenacetin		
Antimony		
Arsphenamide		
Oral Contraceptive Agents		
II. VIRAL		
Measles		
Influenza		
H. Zoster		
V. GRANULOMATOUS		
Tuberculosis		
Leprosy		
Sarcoidosis (?)		
III. FUNGAL		
Trichopytosis		
Coccidiomycosis		
Histoplasmosis		

bodies with common antigenic factors in the skin.

Erythema nodosum occurred in 3.8 percent of the 2,029 cases of ulcerative colitis collected by Warren and Sommers⁸. Sloan, et al⁵, found that 2.3 percent of 3,000 cases of ulcerative colitis at the Mayo Clinic exhibited typical lesion of erythema nodosum. In a review of 125 children afflicted with ulcerative colitis, Michener⁴ reported the occurrence of erythema nodosum in two of their patients. In 112 patients seen with ulcerative colitis over a fifteen year period at the Children's Memorial Hospital, four have had erythema nodosum.

In most instances erythema nodosum approximates the onset of an acute exacerbation of colitis and its subsidence with a relatively quiescent phase of colitis as illustrated by our patient. The duration of the skin lesions associated with each exacerbation may vary from one to five weeks. Erythema nodosum may reoccur and herald a new onset of ulcerative colitis. Brooke¹ found that erythema nodosum accompanied only his severe cases of ulcerative colitis. Jackson and Massell³ noted that the extent of the colon involved did not bear any relationship to the incidence of the severity of the erythema nodosum.

Ulcerative colitis is an acute and chronic inflammatory and ulcerative disease of the colon of unknown etiology. It is a well recognized entity in adults, is seen infrequently in childhood and early adolescence, and has been reported in the newborn infant. Its diagnosis in the pediatric age group may sometimes be exceedingly troublesome. Bloody diarrhea, especially if it is mild, may be overlooked by the parents as pre-adolescent and adolescent children are not very communicative about their bowel habits. It is only through careful questioning that the clinical manifestations of rectal bleeding or mildly loose bowel movements suggestive of early ulcerative colitis can be elicited.

Remissions and exacerbations are common in ulcerative colitis, but in approximately 25 percent of the cases seen on the pediatric age level, only one solitary episode may occur. Children may recover quickly with no recurrences, and may be incorrectly diagnosed as having infectious gastroenteritis. The importance of making a diagnosis is often related to the prognosis. The younger the child the poorer the prognosis because there is usually a more profound

disturbance of growth, development and sexual maturation than would be expected from a chronic debilitating disease. Carcinoma of the colon occurs much more frequently in a patient in whom chronic ulcerative colitis develops in childhood than in the general child population. As in so many clinical conditions, a high index of suspicion will lead to the correct diagnosis. Erythema nodosum as an extra-colonic manifestation of ulcerative colitis represents a distinctive physical sign and may often aid the physician in making a correct diagnosis.

Summary

A 15-year-old diabetic with erythema nodosum as an early manifestation of ulcerative colitis is presented. The literature is reviewed and discussed.

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Consecutive Hydrocephalics

By EUGENE S. WELTER, M.D./JOLIET

The incidence of congenital hydrocephalus is about .5 to 2.5 per 1,000 births.² On the other hand only 25 reports have appeared in which more than one hydrocephalics was delivered to the same woman. R. G. Mehne, M.D., writing in "The Indiana State Medical Association Journal"¹ gives an excellent resumé of the reported cases.

In the case of congenital hydrocephalus the basic pathology is a narrowing of the aqueduct of Sylvius to less than .2 mm. at the point of maximal constriction. This narrowing having been variously attributed to simple stenosis, forking, septum formation, or tumor pressure. Bichers and Adams² were the first to suggest that the mechanism was sex linked and that it was due to a defective gene in the mother's line. Their original report described a family in which all of the three sons and four of the six brothers of a healthy woman died at birth with hydrocephalus, while three sisters and two daughters were not affected. J. H. Edwards³ states that this is a sex linked recessive mechanism with an abnormal gene being carried on an X chromosome, the morbid influence of which is completely eclipsed in the presence of another X chromosome lacking this genetic aberration. Others as reported by

R. G. Mehne¹ have suggested defective germ plasm due to avitaminosis, endocrine abnormalities, drugs⁴ but have little if any support. The sex incidence as reported by D. P. Murphy⁵ is male/female of 170/100 of an hydrocephalic infant and the probability of a second similar defective infant to be born to the family was 24 times greater than to the general population at large. He reported three such consecutive hydrocephalics complicated by spina bifida. In a series at the Mayo Clinic covering 20 years, the ratio was 20 males to 16 females.⁶ The only important single symptom reported by them was hydramnion occurring in six of the 36 cases either with acute or gradual onset.

In my own particular case, the patient has had genetic counseling by H. L. Nadler, M.D., at the Children's Memorial Hospital, Chicago, Illinois. He performed chromosome analysis on the mother and this was normal. He feels that the risks of an affected fetus were probable in the order of 25 percent in each pregnancy.

Case report

This white female patient has had three full term pregnancies. The first pregnancy resulted in delivery on Sept. 11, 1961, of an apparently normal female infant with



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persistent umbilical hernea, pes planus, and nocturnal irritability. The patient weighed 219½ lbs. at delivery, which represented a weight gain of 161½ lbs. during the pregnancy. She was given A.P.C.-amobarbital combination, compazine-dexedrine combination, and hydroxyzine 25 mg. at various times during the second and third trimester as well as acetazolamide 250 mg., triamcinolene 1 mg. chlorpheniramine 2 mg. ascorbic acid 75 mg. combination for allergic pollinosis, and thyroid gr. ii tid. The second pregnancy was marked by an early fear of having any more children and an interdependency between the mother and daughter out of normal proportions. Patient was given a bentyl 10 mg. decapryn 10 mg. pyridoxin 10 mg. combination and a 1,000 calorie diet early in the pregnancy. Given a prednisone 2.5 chlorpheniramine maliate 2 mg. ascorbic acid 75 mg. combination, and acetazolamide 250 mg. in the third trimester. Dexedrine 15 mg. compazine 7.5 mg. combination had been used even before conception. Quinethazone 100 mg. daily started on June 25, 1964. Gained about 16 lbs. Delivered vaginally a 7 lb. 8 oz. male on Aug. 18, 1964, after an eight-hour labor. Live birth with a cephalic presentation. Was a cyclopia with rudimentary cerebral cortex, bifid optic nerves, bilateral microphthalmia, and absent olfactory nerves. A nasal proboscis located above the eye and hydrocephalic. Lived about one hour and expired spontaneously.

Patient weighed 246 lbs. at time of delivery. The third pregnancy commenced on about Apr. 23, 1965. Patient was hospitalized from Oct. 23, 1965 to Nov. 2, 1965, for right lower lobe pneumonia of viral etiology. Also suffered a severe fall with no apparent ill effects on Nov. 5, 1965. Abdominal x-rays taken two months before delivery revealed no evidence of hydrocephalic fetus at that time. Delivered a hydrocephalic breech male on Dec. 18, 1965, after a six-hour labor. Weight gain 44 lbs. Cranial puncture and draining of excessive fluid were necessary to allow vaginal delivery to be accomplished, the patient in this instance having experienced a marked enlargement of her abdomen during the last six weeks. It was estimated the polyhydramnios in her case contained about one gallon of fluid, and the hydrocephalic head contained about three quarts of fluid. Autopsy reported 5 lb., 3½ oz. male with hydrocephalus, congenital with cyclopic like brain malformations. Fusion of cerebral hemispheres with lateral ventricles a single cavity. Congenital single nostril of nose. Drugs in this pregnancy were held to a minimum because of previous hydrocephalic and paper by M. M. Scheffler⁴ based on that case.

Conclusion

In your counseling of the parents who have been unfortunate enough to have had an hydrocephalic infant, don't be too dogmatic in your denial that it could

DRUGS USED

Acetazolamide 250 mg.
Amobarbital ½ gr.
Aspirin 2½ gr.
Phenacetin 2½ gr.
Dexedrine 5 mg.
Dexedrine 15 mg.
Compazine 7.5 mg.
Hydroxyzine 25 mg.
Triamcinolone 1 mg.
Chlorpheniramine 2 mg.
Ascorbic acid 75 mg.
Bentyl 10 mg.
Decapryn 10 mg.
Pyridoxine 10 mg.
Prednisone 2.5 mg.
Chlorpheniramine maliate 2 mg.
Quinethazone 50 mg.

TRADE NAME

Diamox
Daprisol

Eskatrol
Vistaril
Aristomin

Bendectine

Metreton

Hydromox

COMPANY

Lederle
Smith, Kline, & French

Smith, Kline, & French
Pfizer
Lederle

Merrell

Schering
Lederle

happen to them again, because it could. Their chances are 24 times greater than the average couples or in the order of 25 percent in each pregnancy. You can assure them of its marked rarity—only 26 reported incidences—and also be re-assuring in your counseling to the fact that these incidences are apparently sex linked and not caused by environmentally controlled factors.

Summary

The probabilities of the same woman delivering more than one hydrocephalic infant are discussed, the pathology and probable sex-linked cause are put forth, a review of the previously reported twenty-five cases is presented, and another case history is summarized.

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A Face Saving Procedure

(Continued from page 167)

Marginal resection will not be appropriate for cancers invading the mandible or involving the mental canal, or in bulky intraoral neoplasms where a substantial amount of soft tissue must be sacrificed and wound closure would be otherwise impossible without sacrifice of the mandible. Nor is the procedure indicated in gingival cancer where a recent tooth extraction has been performed. Almost certainly cancer will involve the mandibular cavity in such cases.

It is not the intent of this essay to weigh the merits of marginal resection versus total segmental resection of the mandible in terms of cure. The two procedures should have comparable results if patients are properly selected.

Conclusion

Marginal resection of the mandible for neoplasms of the anterior oral cavity is a sound cancer operation in properly selected patients. Two such cases are presented in which both speech and deglutition are well preserved and the cosmetic result is very gratifying.

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THE NURSE OF THE FUTURE

Presently the trend in nursing education is toward university preparation of the professional nurse. This is opposed to what is being controversially labeled a "nursing technician" who is a graduate of a two- or three-year program. It is my belief that the professional nurse of the future will be prepared with a master's degree, choosing a specialty in a clinical area, nursing administration or education. She will plan for and direct the care of the patient through others rather than performing the care herself. The clinical specialist will return to the patient's bedside to "mold the role of nursing to suit each patient's needs. This will involve assessing patient's needs, planning with others to give the care and evaluating the care given. Limits to the kinds of decisions the specialists will make will be established by doctors, nursing service administrators and the nurse clinician, herself."

Professional nursing is perceiving what needs to be done and how to do it. It is now concerned with developing the climate in which necessary changes can occur.

Henry Ford Hosp. Med. Journal Vol. 15, No. 3, 1967



THE VIEW BOX



BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

This one-month-old normally delivered premature white female infant was admitted to the hospital with a two day history of severe diarrhea and high fever. Enterococci were cultured from blood, stools and urine. In spite of massive antibiotic therapy the child died three days after admission.

WHAT'S YOUR DIAGNOSIS?

1. Pneumatosis intestinalis.
2. Necrotizing enterocolitis and portal vein gas.
3. Biliary tract fistula.

(Answer on page 187)

Argentaffinoma of the Appendix in Pregnancy: Report of A Case

By RUSSELL C. SCOTT, M.D., AND THOMAS W. McELIN, M.D., M.S. / EVANSTON

Tumors of the appendix are rare; however, the most common is the argentaffinoma or carcinoid tumor⁷. Recently, four cases of appendiceal argentaffinomas associated with pregnancy were described¹. Prior to this report, only two other instances of this tumor associated with pregnancy had been found in a review of the literature dating back to 1916. One of these involved the appendix²; the other, the rectum⁶. We present, herewith, a previously unreported instance of appendiceal argentaffinoma associated with pregnancy.

Case Report

A 36-year-old white, gravida 4, para 3, had had three prior uncomplicated pregnancies and deliveries. Two weeks after the third delivery, excessive vaginal bleeding had occurred, which was controlled by oral ergotrate. She was admitted at term for her fourth delivery on Oct. 12, 1959, in active labor. A normal 8-pound, 8-ounce male infant was delivered by low forceps after a short labor. Her prenatal course was unremarkable and her postpartum course in the hospital was normal.

On Oct. 19, 1959, the patient was readmitted with heavy vaginal bleeding. The uterus was curetted and packed, but the hemorrhage continued. The procedure was repeated, but to no avail. Subsequent microscopic examination of the curettings revealed no villi, and the pre-curettement diagnosis of noninvolvement of the placental site⁵ was sustained. Because of the con-

tinuing deterioration of patient's condition, total abdominal hysterectomy was performed. During the combined procedures, five units of plasma and five units of whole blood were administered. Later, she received three more units of blood to correct severe anemia. At the time of hysterectomy, a large, irregular, nodular tumor involving most of the appendix was found. A mucoid substance exuded from this mass. Appendectomy with wide excision of the mesoappendix was performed.

The tumor was in the lower three-fourths of an 8-cm. long appendix and measured 6 x 3.5 cm. The serosa was pink and moderately injected. The lumen of the mass was filled with a gray-white mucoid material. The lining was gray and smooth, and the wall was 1 mm. thick. The proximal lumen of the appendix was obliterated. Microscopic examination of the nonsaccular area showed numerous irregular masses, nests, and clusters of solidly packed tumor cells with round-ovoid, darkly staining nuclei, involving the submucosa, muscularis, subserosa, and part of the mesoappendix. The proximal margin of the appendix was free of tumor by 1 cm., and tumor did not extend to the resected margin of the mesoappendix. Sections from the saccular area of the appendix showed flattening of the wall and disappearance of the mucosa. The final pathologic diagnosis was argentaffinoma of the appendix with extension to the mesoappendix (Figs. 1 and 2).

After surgical consultation, in view of the local extension of the tumor, its large size, and its gross appearance, right hemicolectomy was advised.

The patient was readmitted on Dec. 4, 1959, for this purpose. Preoperative study revealed normal urinary 5-hydroxyindole acetic acid, normal barium enema, normal electrocardiogram, and normal proctoscopy to 15 cm. On Dec. 8, 1959, the right hemi-

Dr. McElin is Professor and Chairman of the Department of Obstetrics and Gynecology at Northwestern University Medical School. A graduate of Harvard, Dr. McElin served his internship at Passavant Memorial Hospital, Chicago, and a residency at the Mayo Clinic in Rochester, Minn. Dr. Scott is engaged in the practice of obstetrics and gynecology in DeKalb. He received his medical degree from Washington University Medical, St. Louis, Mo., and was a resident at Evanston Hospital, when this paper was prepared. Additional residencies were served at the University of Kentucky Medical Center and Cook County Hospital, Chicago.

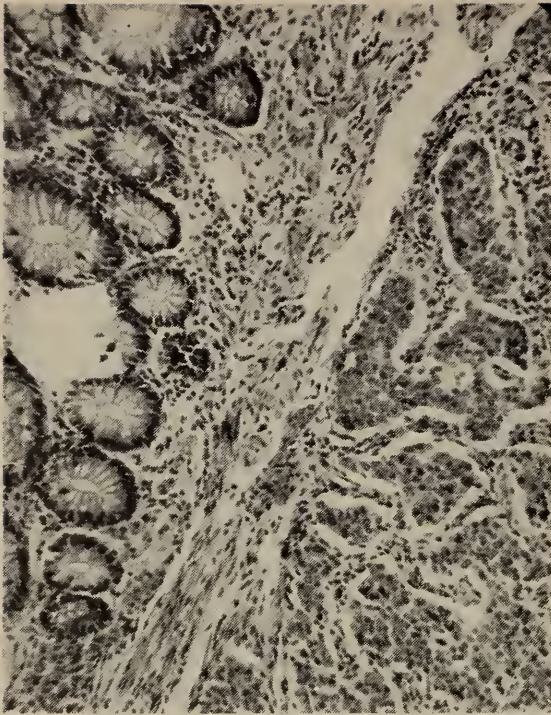


Fig. 1. Clusters of carcinoid cells in proximity to appendiceal glands.

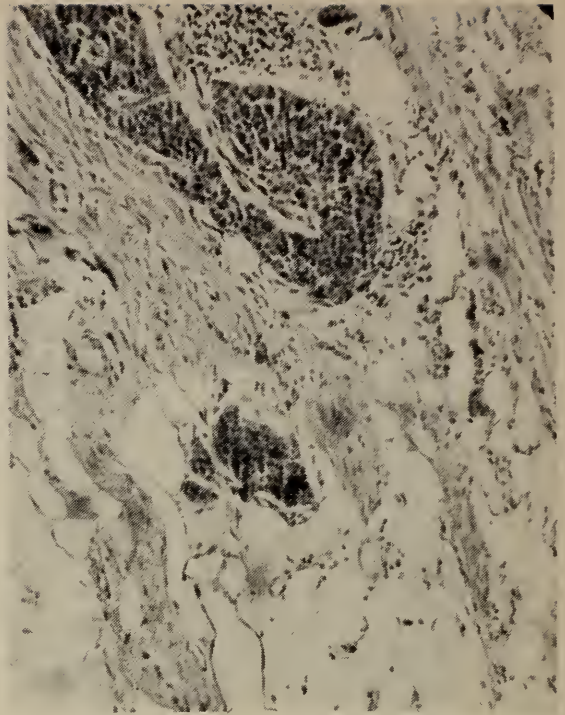


Fig. 2. Invasion of serosa by clusters of carcinoid cells.

colon and part of the ileum were removed. No gross evidence of tumor was found. The pathologist's report revealed no lesion in the ileum, colon, or five lymph nodes submitted for examination.

The patient had an unremarkable post-operative course. She remains alive and healthy six years after delivery.

Discussion

Argentaffinomas were originally called carcinoids by Oberndorfer in 1907 because they resembled carcinoma. They are now more precisely designated argentaffinomas because cytoplasmic granules in the cells of this tumor have an affinity for silver salts. Approximately 60 percent of these unusual tumors are located in the appendix, and approximately 85 percent in the ileocecal area⁷. They are also found in the small intestine and, less often, in the stomach and rectum. Occasionally, the colon, biliary tree, pancreas, and bronchus are involved. The tumor most frequently involves the distal tip of the appendix.

Appendiceal argentaffinomas rarely metastasize, whereas the extra-appendiceal lesions metastasize in approximately 38 percent of cases⁷. O'Sullivan and Bowe⁴ reported on 28 cases of argentaffinoma of the appendix. Of these, simple appendectomy sufficed as treatment in 26 cases. However,

of the two patients remaining, one was found at autopsy to have an argentaffinoma of the appendix metastasizing to the liver, lymph nodes, pancreas, ovary, and broad ligament. The other was found to have invasion of the mesoappendix after incidental appendectomy, and, therefore, a right hemicolectomy was performed 18 days later.

Similarly, right hemicolectomy and partial ileectomy were performed in our patient because of invasion of the mesoappendix.

Of the four cases occurring in pregnancy reported by Berrios et al¹, all would be considered invasive, in that tumor cells were found in the muscularis of the appendix. Simple appendectomy sufficed as therapy. The patients had no difficulty with their pregnancies. Thus, it may be concluded that the tumor apparently had no effect on the pregnancies. In our patient, the pregnancy also progressed normally, as there were no symptoms relating to the tumor which was found incidentally at the time of postpartum hysterectomy.

The carcinoid syndrome per se has not been reported in pregnancy. Since the tumors reported in pregnancy mainly involve the appendix, this is reasonable. The carcinoid syndrome usually signifies malignant carcinoidosis of the liver and, therefore, a high blood level of serotonin³. This ele-

New Pfizer Diagnostics Test Offers Simple and Rapid Method for Measuring Serum Cholinesterase

A new test set for rapidly measuring the concentration of cholinesterase enzyme in blood serum, a useful parameter of general liver function and a definitive laboratory confirmation of organic phosphate pesticide intoxication, has been introduced by Pfizer Diagnostics, department of Chas. Pfizer & Co., Inc.

The product, trademarked ChE-tel, marks Pfizer's first entry into the field of clinical enzymology.

Increased serotonin blood level occurs because serotonin formed in the liver metastases directly enters the circulation without destruction, whereas serotonin from intestinal lesions is carried through the portal system and is inactivated in the liver by monoamine oxidase to increase the level of 5-hydroxyindole acetic acid in the urine (without producing symptoms of the carcinoid syndrome). If the serotonin comes from lesions outside the portal system, the carcinoid syndrome may result without liver metastases.

As Berrios et al¹ observed, one would expect argentaffinomas to be found more frequently in appendectomies performed in pregnancy, since their incidence in appendectomies in the general population is 0.2 to 0.5 percent⁸.

Summary

An additional case of argentaffinoma (carcinoid) of the appendix during pregnancy is reported.

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According to Pfizer Diagnostics, the ChE-tel test set offers a simplified diagnostic procedure which is easier to perform than conventional pH measurement techniques. By quantitatively determining serum cholinesterase concentration, ChE-tel provides an invaluable diagnostic and prognostic aid for specialists in internal medicine, anesthesiology, electro-shock therapy, and chronic and acute toxicity.

For example, in acute pesticide poisoning, cholinesterase levels drop rapidly and can be used as a measurement of response to treatment with atropine and pralidoxime. Measuring cholinesterase levels is also useful in predicting response to neuromuscular blocking agents such as succinylcholine, administered prior to surgery or psychiatric therapy.

ChE-tel may also render a valuable diagnostic service in the treatment of liver disorders and chronic poisoning from other chemical agents that lower cholinesterase levels such as opiates, barbiturates, quinidines, and nerve gases.

In addition to its use by hospitals and clinical laboratories, Pfizer Diagnostics foresees widespread application of ChE-tel by poison and pesticide control centers; manufacturers of industrial chemicals, fertilizers, pesticides, agricultural chemicals and chemical specialties; agricultural research centers; government health centers; medical institutions; and research departments of colleges and universities.

The ChE-tel procedure is based on the liberation of thiocholine from a unique substrate reagent by the action of serum cholinesterase. The released thiocholine is then reacted with a buffered reagent to form a yellow-colored anion. The intensity of the yellow color developed is directly proportional to the concentration of cholinesterase, and can be measured colorimetrically.

The ChE-tel test set contains a sufficient quantity of reagents for 50 cholinesterase determinations. When stored under refrigeration (2° to 8°C.), all reagents are stable for one year. The price per set is \$25.

Complete information can be obtained on request from Pfizer Diagnostics, 300 W. 43rd St., New York, N.Y. 10036.

Asthma: A Panel Discussion

The vast majority of asthma patients in the United States are not adequately cared for because most physicians have not received sufficient training in the management of this disease, claims a leading allergist. An estimated 12,500,000 persons suffer from asthma and/or hay fever, with 5 to 6 million of these afflicted by asthma. Yet there are fewer than 1,300 allergists in the country, declared Dr. Murray Dworetzky, Clinical Professor of Medicine at Cornell University Medical College, and Attending Physician and Physician-in-Charge, Allergy Clinic, The New York Hospital. Until more specialists can be trained, non-specialists must be educated to handle allergic illness, he stated.

Speaking at a recent panel discussion, Dr. Dworetzky, who is also president-elect of the American Academy of Allergy, said that "centers devoted to care, research and training in the field of allergy are vital to the welfare of every one of the millions of asthma patients in this country."

"The function of these centers is not merely patient care; more important purposes are research and teaching. The applied, clinical research being turned out by these institutions is filling a major need in improving patient care. The allergist is aware that even our current admittedly inadequate knowledge of the care of the asthmatic patient is not being utilized. So the number one function of a center is education."

He said that although asthma is not considered one of the killers, and 0.1 percent doesn't sound like much, it comes to between 5,000 and 6,000 deaths each year. It is an enormously disabling and therefore costly disease. Estimates based on surveys carried out during the past 10 years vary up to 37,000,000 bed disability days lost from work each year because of asthma and hay fever, obviously the primary cause being asthma. This compares with about 16,000,000 days lost from all strikes and work stoppages in the country in 1961.

"Children under 17 years of age lose more

than 9 million days of school and spend about 13 million days in bed each year due to allergic disorders, primarily asthma. This makes it the commonest cause of disability among school children of all chronic disease."

Asthma patients function well for many years, Dr. Dworetzky asserted, and often "pant into old age." But despite all that is done to help them, their incapacity may grow to the point where many must give up working, spend their savings, and wind up on the welfare rolls.

The role of the asthma-allergy center is to take care of the tiny percentage of the total asthma population in such a way as to serve as a model for lesser institutions, to train physicians who then move to other communities and set up first-rate comprehensive units for continued study and treatment of asthmatic patients.

Martin Nacman

The social and emotional problems of the asthma patient can be as difficult as the physical disease itself and require a complete program of psychological and vocational rehabilitation. "The chronic asthmatic patient may rely very heavily on his asthma," stated another panelist, Martin Nacman, director of rehabilitation at the National Jewish Hospital at Denver. "He often has not had the opportunity or the motivation to participate in experiences usual for his age group, and may be distrustful of the helping professions, at least until he is sure that he has been helped by them."

"The evidence indicates that in asthma we are not dealing with a single personality but with different patterns in different people," Mr. Nacman said. "For some, physical factors seem predominant; for others, emotional and social problems appear to be equally as important. In either case, having asthma for a prolonged period and growing up in a restricted environment results in additional problems that at times are as difficult as the physical condition."

"The old idea that asthmatics must be relatively inactive is gone. "They obviously can't go to school or play ball when they are in the throes of an attack, but once the attack is over they may return to normal schedules. Adult patients often work in a

This panel discussion was presented as part of a symposium conducted recently in New York by the National Jewish Hospital, Denver, Colo., and the Rehabilitation Services Administration of the U. S. Department of Health, Education and Welfare.

sheltered workshop, where training in special skills can be acquired for use after they leave the hospital, and they receive nominal wages while there. Daily physical therapy should be provided for patients whose physical tolerance is quite low."

Dr. Aaron Paley

"Asthma is never a purely psychological disease however; it always has an allergic cause, although stress can bring on an attack," contends Dr. Aaron Paley, chief of the department of psychiatry at the National Jewish Hospital at Denver. "While it is true that the patient with asthma does have psychological attributes that can be described," he declared, "there is no underlying conflict, no personality type, no special trait or family pattern that is common to and unique for all asthmatic patients. The disease is not a purely psychological entity. It has an immunological, biochemical, or histopathological foundation. One can do a vast amount of good for the patient by simply remembering that he is a complex, but still understandable, individual trying to get along with a difficult burden in a difficult world."

The importance of attitudes was stressed by the psychiatrist, not only the attitude of the patient but those of his family, friends and doctor, all of whom are subject to varying amounts of detrimental and demoralizing attitudes such as apprehension, anxiety, oversolicitude, plus cycles of self-pity and reactive anger on the part of the patient. All tend to repeat or to re-enact patterns learned to use with significant people at an earlier time. If a behavior pattern is detrimental to the asthma patient, he must unlearn it. Psychiatric treatment will help him to do so.

Repetitive behavior patterns are stubborn and tenacious, and mothers are not the only ones who become over-protective or angrily frustrated. Doctors, even allergists and psychiatrists, easily develop a large emotional investment in a youngster to whom they have conscientiously ministered for months, particularly if this included an episode of agonizing, all-out, life-and-death emergency. It is the job of the psychiatrist to help patients unlearn behavior patterns that are detrimental to them. This is as much a part of rehabilitation as any other aspect of treatment.

Dr. Elliott Middleton, Jr.

"A variety of drugs used singly or in combination are opening up a new and

promising era in the treatment of asthma," according to Dr. Elliott Middleton, Jr., associate attending physician in medicine and allergy at Roosevelt Hospital, New York. One of these is a cortisone derivative which, when used with discernment, brings great relief and should not be viewed fearfully by the patient who has heard of its side-effects, Dr. Middleton said. The other drugs include adrenalin, aminophyllin, ephedrine, and expectorants. All these familiar drugs are interrelated in their effects so that when one does not work properly the addition of one of the others may produce good results.

"The hallmark of the bronchial tree of an asthmatic is that it is over-reactive to various stimuli," stated Dr. Middleton. "If adrenalin manufactured by the patient's own body isn't working properly, then the airways constrict, causing wheezing or breathlessness. Synthetic adrenalin by injection or by aerosol mist will usually dilate the airways. But sometimes it takes the use of one of the other drugs *with* adrenalin, to bring relief." Some understanding of how these drugs work in concert with each other now is developing in the research laboratory. Aminophyllin prevents the destruction of a chemical formed by adrenalin, which may be responsible for the final broncho-dilating effect. If the attack is severe, perhaps all three of these drugs may be necessary to restore natural breathing.

Cortisone and its derivatives have received an unwarranted reputation as dangerous remedies. They are powerful drugs and sometimes create side reactions, but ways have been worked out in recent years to give these compounds so they are less likely to cause side-effects and especially not to depress the action of a patient's own adrenal glands. By controlling the dosage and giving the drug at particular times of the day — or perhaps every other day instead of daily — relief without complications occurs at least 50% of the time. Some of the most severe asthma patients may now be treated with assisted breathing or controlled breathing under anesthesia in the hospital. These newer forms of treatment involve the cooperation of allergists, chest specialists and anesthesiologists.

Nobody knows the precise cause of asthma, Dr. Middleton said, but "we are working now on the idea that asthmatics do

(Continued on page 196)

University of Illinois Accepts \$618,771 in Research and Training Grants

The University of Illinois Medical Center Campus, Chicago, has accepted an overall total of \$618,771 in research and training grants for the period of Oct. 2-31. Out of 24 grants listed, 17 grants totaling \$576,387 were from the United States Public Health Service.

The funds were allocated as follows: \$21,903, College of Dentistry; \$436,959, Col-

lege of Medicine; \$159,909, Office of Student Affairs.

The largest single grant, \$249,310, was awarded to Dr. Harry F. Dowling, professor and head of the Department of Medicine in the College of Medicine, by the United States Public Health Service for the "General Clinical Research Center."

The grants for the College of Medicine are listed below:

Special Fellowship Award	\$15,000, Public Health Service	Dr. Samuel R. Reynolds, professor and head, Department of Anatomy
Protein Metabolism in Oral Tissues	\$19,500, Public Health Service	Dr. Henry Jeffay, associate professor of biological chemistry
Isolation and Structure of Acid Mucopolysaccharides	\$34,124, Public Health Service	Dr. Bernard Weissmann, associate professor of biological chemistry
Connective Tissue Defects in Pulmonary Emphysema and Vice Versa	\$7,078, Tuberculosis Institute of Chicago & Cook County	Dr. Robert W. Carton, associate professor of medicine
General Clinical Research Center	\$249,310, Public Health Service	Dr. Harry F. Dowling, professor and head, Department of Medicine
Clinical Pharmacology of Spirolactones	\$12,000, G. D. Searle & Co.	Dr. Clarence L. Gantt, assistant professor of medicine & assistant supervisor of clinical research center
Clinical Pharmacologic Studies of Diuretic Agents	\$2,500, Hoechst Pharmaceutical Company	Dr. Clarence L. Gantt
Clinical Pharmacologic Studies of Anti-Hypertensive Agents	\$3,000, Cutter Laboratory Berkeley, Cal.	Dr. Clarence L. Gantt
Fellowship Stipend	\$1,000, Public Health Service	Dr. Alfred Nisonoff, professor of microbiology
Spinal Synaptic Transmission and Biogenic Amines	\$17,484, Public Health Service	Dr. Edmund G. Anderson, assistant professor of pharmacology
Fellowship Stipend	\$275, Public Health Service	Dr. Harold Feinberg, associate professor of pharmacology
Adenine Nucleotide 6-NH ₂ Metabolism in Heart Muscle	\$8,683, Public Health Service	Dr. Harold Feinberg
Correlated Analysis of the Orthogonal Vectorcardiogram in Children	\$6,806, Chicago Heart Association	Dr. Alois R. Hastreiter, assistant professor of pediatric cardiology
Energy Metabolism of Experimental Myocardial Lesions	\$5,915, Public Health Service	Dr. Pietro O. Bramante, associate professor of physiology

Role of Phosphate Metabolism in Transport	\$25,482, Public Health Service	Dr. Akira Omachi, associate professor of physiology
Experimental Spasticity in the Monkey	\$4,000, Spastic Paralysis Research Foundation	Dr. Arthur Kling, associate professor of psychiatry & director, biological research laboratories
Isolated Perfused Bovine Liver	\$7,000, Ayerst Laboratories New York, New York	Dr. Lloyd M. Nyhus, professor and head, Department of Surgery
Glycoprotein Biosynthesis in Shock	\$17,802, Public Health Service	Dr. William Schumer

— THE VIEW BOX —

(Continued from page 180)

DIAGNOSIS: Necrotizing enterocolitis and portal vein gas.

Gas in the portal venous system has been reported in 32 patients of which 14 have been infants. In children portal vein gas has been seen in the following: necrotizing enterocolitis in premature infants, intestinal obstruction with peritonitis in imperforate anus and duodenal atresia, idiopathic diarrhea and mesenteric vein thrombosis with gangrene of the bowel. In adults the most common cause was mesenteric vascular occlusion with bowel necrosis and acute hemorrhage pancreatitis.

The origin of the gas in the portal vein is undecided. One theory suggests that gas under tension in the bowel escapes into the mesenteric vein and portal vein through a bowel wall altered by impaired circulation. Another more popular theory suggests that the gas is produced by enteric organisms which have gained access to the vascular system through compromised bowel wall.

The roentgen appearance of gas in the portal vein system is a linear branching gas pattern in the right upper quadrant radiating outward to the periphery of the liver. This appearance distinguishes it from gas in the biliary tree where the gas remains centrally located in the region of the porta hepatis. It is considered to be a grave prognostic sign, only one case with survival having been reported.

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Schwab Hospital Offers New Pulmonary Rehabilitation Service

A new program to provide comprehensive evaluation and treatment for patients with chronic pulmonary disabilities is being offered at Schwab Rehabilitation Hospital, Chicago. Benefiting will be persons suffering with bronchitis, emphysema, bronchiectasis, and pneumoconiosis.

Providing both medical and rehabilitation services for those chronically disabled

is the purpose of the program. Medical treatment includes the use of antibiotics, aerosol, oxygen, broncodilators, and mucolytic agents. Breathing exercises, postural drainage, psychological assessment, pre-occupational evaluation, and social service support will be the basis of the rehabilitation program. Any patient who might benefit is admissible for evaluation and treatment.

A Socio-Economic Report

Medicaid and Foster Children

On July 1, 1967, the nearly 7,000 children who are under the guardianship of the Illinois Department of Children and Family Services became eligible for Medicaid Coverage.

What does this mean to Illinois physicians? Who are these children? What are their medical needs—and who provides their medical care?

To answer these questions, and to learn more about the relatively new Department of Children and Family Services, the ISMS Division of Public Relations and Economics interviewed Dr. J. Keller Mack, the Department's Medical and Public Health officer.

Dr. Mack, when and why was the Department established?

It was established by the Illinois General Assembly in 1963 to strengthen the state's public child welfare programs. The Department provides an administrative framework for providing non-psychiatric programs which were formerly administered by the Department of Mental Health.

What are those programs?

We have many, of course, but they all fall within one of three program divisions—Child Welfare, Children's Schools, and Rehabilitation Services. Child Welfare is the core division, with about 12,000 children and 6,300 families receiving services monthly.

What kind of services?

They range from family counseling by social workers in our field offices to providing help to unmarried mothers. The division has responsibility for licensing child care agencies and institutions and it operates the Lawndale Day Care Center in an economically depressed area of Chicago. We provide homemaker services, help with

adoption matters and counseling to the families of mentally retarded children. And of course, we provide protective services for children in their own homes and through foster homes and institutional care. We have about 7,000 children for whom we serve as guardian either through court order, surrender or voluntary agreement with their parents.

How do these children come to the Department's attention?

Through referrals from juvenile courts, school officials and other social agencies. And, of course, many complaints that children are being neglected are filed by neighbors—or by one of the parents of a child. Then, too, the state Child Abuse Law—which requires mandatory reporting by physicians and hospitals of suspected abuse cases—represents a relatively new case-finding tool.

Has the Child Abuse Law materially increased the Department's case load?

To a degree, yes. Physicians and hospitals are doing a good job of reporting suspected abuse cases. For example, we have had 1,136 reports filed in the first two-and-a-half years of the law's existence. But more important—in terms of total caseload—the creation of the Department of Children and Family Services meant that for the first time, Illinois has a statewide public agency which provides child welfare services not available through other public or voluntary agencies.

Are most children served by the Department placed in foster care?

Yes, the greatest number are living in some type of foster care arrangement. However, the greatest rate of growth has been through expansion of services to children in their own homes—services such as fam-

ily counseling, homemaker service, day care and child protection.

How do the medical needs of the Department's foster children differ from other children?

Basically, they don't. There is just more "catching up" to do. Remember, in most instances, these children have been grossly neglected—inadequately clothed, malnourished and sometimes even starved. Many have physical defects resulting from lack of any preventive medical services, and there is usually a need to bring their immunizations up-to-date. True, some foster children are adopted, but youngsters with physical handicaps are the least likely to find permanent adoptive homes. And this is one reason why the medical needs of some foster children may be even greater than those of children living in their own homes.

Who pays the medical expenses of these foster children?

It all depends on who the foster child is, and what type of medical service he needs. For example, the Department of Children and Family Services pays for preventive health care services, such as routine periodical physical and dental examinations. The Department also pays all medical bills for foster children not eligible for Medicaid.

Does the Illinois Department of Public Aid pay any of the medical expenses for these children?

Yes. Most wards of the Department of Children and Family Services are Classified as "medically indigent" and are eligible for Medicaid. Since the Medicaid program is administered in Illinois by the IDPA, that Department pays the bills for diagnosis and treatment of non-psychiatric disease or pathology. Public Aid also pays for school examinations and immunizations required by the Illinois School Code.

Why can't the Department of Children and Family Services make the payments, rather than IDPA?

Because it is accepted policy for all state agencies to use every potential funding resource in providing services to Illinois residents. This means full participation in those programs—such as Medicaid—which make federal funds available on a matching basis to the state.

Are the foster children receiving good medical care under this program?

Generally, they are. But we have some problems. As with any new venture, the first six months of this medical payments program have been marked with misunderstanding on the part of physicians, pharmacists, other medical vendors, and among personnel of the agency itself.

What are the problems?

For one, we have found a definite reluctance among some physicians to participate in providing care for these children. Some doctors object to the paperwork and "red tape" in filing the forms required before the Public Aid Department can pay the bill. Other doctors have different objections. As a result, there have been instances in which physicians have refused to give non-emergency treatment to foster children whose medical bills are paid by IDPA. Foster mothers and-or social workers have been forced to "shop around" for a participating physician and to travel long distances to obtain adequate treatment. I think we would all find it unfortunate if any doctor would deny needed services because of who pays what for specific medical procedures.

Can you suggest solutions for the problems?

I think so. The remedy lies in the cooperation of all physicians in providing services to these children. The big factor is the physician's attitude. If he realizes that foster children are among the most needy in our society, then I think he will be willing to bear some of the "inconveniences" which invariably accompany programs of this type.

Drug Industry

(Continued from page 132)

The survey report revealed that \$37 million was spent for research capital, plant and equipment investment last year, increasing the total value of such facilities to \$273 million.

PMA is a non-profit, scientific, professional and trade organization representing the manufacturers of more than 95 percent of the nation's prescription drug products.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Board Approves Sponsorship of Professional Liability Insurance Program

The ISMS Board of Trustees has approved society sponsorship of a professional liability (malpractice) insurance program to be underwritten by the Employers Group of Insurance Companies of Boston, Mass. The program—similar to one now sponsored by the Florida Medical Association—has four primary objectives: creation of a stable, enduring insurance market for the majority of ISMS members; creation of a proper legal climate; development of a program of malpractice claims prevention; and maintenance of appropriate premium charges. The program—effective July 1, 1968—will be explained in a forthcoming *Illinois Medical Journal*.

* * *

How To Expedite Claims for Treatment of IDPA Patients

Note to physicians treating public aid patients: If you don't receive payment from the Illinois Department of Public Aid within 60 days after providing a service, **do not** re-submit your bill! It will result only in further delay and confusion. Instead, for quick action, write to Robert G. Wessel, Chief, Medical Administration, IDPA, 400 South Spring Street, Springfield, 62706. Include in the letter pertinent information, including the patient's name and IDPA number.

* * *

Military Dependents' Medical Care Program Reviewed

Last July 1, the federal government began paying usual and customary fees to physicians who treat military dependents. How has the program worked? According to J. J. Wrabetz, the program's administrator for Mutual of Omaha, "Our experience to date indicates that charges by physicians can be handled very easily." He said it now takes approximately 30 days to process claims, but the goal is to cut processing time to about five days. Some bills, he added, have been reduced, but in all such cases the doctor may appeal to Mutual of Omaha. If he feels it necessary, he may also appeal to the appropriate committee of his county medical society. Initial appeals should be directed to J. J. Wrabetz, CHAMPUS, Box 1298, Omaha, Nebraska 68101. CHAMPUS is Civilian Health and Medical Program of the Uniformed Services—a new name for the Military Dependents' Medical Care Program.

* * *

Survey Reports Physician's Incomes on Rise

Medical Economics magazine reports that physicians' incomes rose 11 percent in 1966 to a median level of \$32,170 per year. It cited government payments under Medicare as a factor in the increase. The figure is based on a survey of

2,028 doctors under age 65. The median figure means that half the doctors surveyed earned more and half earned less.

* * *

Hospital Planning Council Calls for Modernizations

Fifty-eight of the 69 non-federal, short-term hospitals in Chicago are obsolete, according to the Hospital Planning Council for Metropolitan Chicago. Dr. Eric Oldberg, president of the Chicago Board of Health, disagrees. He said that while there is a need for improvement of facilities, "most of the hospitals have built recent additions which have upgraded tremendously the caliber of hospital service available here." The Planning Council estimated that it would cost more than \$372 million to modernize the hospitals and more than \$719 million to replace them.

* * *

Customary Fee Profile Established

A fee profile on every physician who treats public aid patients has been compiled by the Department of Public Aid. The Department's purpose is to assure that doctors are paid their usual and customary fees. An accurate profile is possible only if physicians continue to bill the fee they customarily charge for a particular service.

* * *

Univ. of Ill. Medical Technology Students on Increase

Enrollment in the Medical Technology curriculum at University of Illinois College of Medicine totals 13—or more than double the total of six enrolled when the curriculum was first offered in 1965. Students enter the course in their senior year. Upon graduation, they may take a national qualifying examination given by the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists. The Board is the only such body recognized by organized medicine in the United States.

By Marvin Schroder

Insurance Executive Cites 5 Reasons for Rising Medical Costs

A specialist in health insurance has attributed "skyrocketing" medical costs to five factors: today's patient is able and willing to pay more; he is making greater use of existing health services; his insurance coverage has broadened; hospital labor costs keep rising and governmental health programs are increasing.

According to Morton D. Miller, vice president and actuary of The Equitable Life Assurance Society, "increasing costs probably will be with us for as long as the economy sails along and people in this country place high values on health." But he said, "there is no earthly excuse for our not getting full value for every last cent in every dollar we spend."

To get more value, it has been suggested that the concept of group practice for doctors be expanded, Mr. Miller said.

Other suggestions, he added, include greater use of auxiliary health personnel, finding new and better ways of delivering health services, improving hospital efficiency and providing more comprehensive insurance coverage.

"The health system needs hard-headed management counsel," Mr. Miller declared. "Business," he said, "has an obligation to participate in comprehensive health action-planning, community by community." Communities, he added, need the voluntary participation of individual business executives.

It has also been suggested, Mr. Miller said, that expanded group practice would enable doctors to serve more patients by permitting them to set up common facilities and treat, at lower cost, patients they otherwise now serve in hospitals.

Wider use of auxiliary health personnel, Mr. Miller explained, would free the physician's time to do those things which only he is qualified to perform. He suggested further expansion of the role of the nurse and said perhaps we could develop the civilian counterpart of the voluntary medical corpsman.

Future research and development activities will likely show the way to cost-cutting measures in delivering health services, Mr. Miller said. "Partnership" activity aided by the proposed National Center for Health Services Research and Development, he said, may give answers as to whether a future health care system develops around preventive and chronic care facilities combined with hospitals, around the method of payment, around group practice, combinations of these, or something completely different.

Mr. Miller proposed that hospital costs can be kept down through improved management, better systems of cost accounting,

and further automation of records. He said: "We can also expect a searching attempt to find new ways for reimbursing hospital costs which will have incentives built in for efficiency and cost improvement."

More comprehensive health insurance benefits, he said, will result in a more balanced coverage of a broader spectrum of medical services. Insurers, he declared, "have major responsibilities to help improve not only the financing mechanism, but the effectiveness of health care and the systems through which it is provided."

Mr. Miller said that the health benefits system has been geared to hospital support, and the buyers of insurance have accepted what the sellers of health care had to offer. Future benefits, he said, will be designed to give direct incentives for improvements "to assure our money's worth for the health care dollar, to assure a better balance in the health care system."

VA Conducted 6,000 Research Projects in 1967

Almost 6,000 separate medical research projects, including some of the world's most significant findings in care of heart disease patients and senior citizens, were conducted in Veterans Administration facilities during fiscal year 1967.

A total of 5,961 medical investigators participated in the \$44.2 million program.

Among the most significant of VA's medical research projects are its cooperative studies through which medical investigators at a variety of VA field stations studying the same problem. One such study conducted last year involved many different doctors, patients and hospitals in comparing treatments for hypertensive patients. The cooperative program settled an old medical debate by establishing definitely that the treatment of hypertensive patients with appropriate drugs would prolong their lives and reduce other complications.

Out of VA's 165 hospitals, 140 were involved in extensive research activities. In addition to the 140 hospitals, research projects were conducted at four outpatient clinics, one domiciliary and the VA Central Laboratory at the Armed Forces Institute of Pathology.

VA investigators contributed 3,669 arti-

cles to professional and scientific journals and presented 3,495 papers at scientific and professional meetings. VA medical findings were reported also in 143 exhibits and 104 motion pictures.

Life Insurance Industry Grants Total \$1.5 Million in 1967

Grants and fellowships totaling nearly \$1.5 million were awarded in 1967 by the Life Insurance Medical Research Fund.

The Fund, which is supported by 138 life insurance companies in the United States and Canada, has distributed nearly \$22 million since it was organized in 1945.

James F. Oates, Jr., chairman of the board for the Fund, notes in the annual report that four of the scientists who have been aided by its grants have also been awarded Nobel Prizes.

Mr. Oates, who is chairman of the board of the Equitable Life Assurance Society, said that many of the other scientists aided by the Fund have produced "a great wealth of new knowledge which has led to the development of new techniques for both research and treatment in the future." Much of the Fund's emphasis has been on basic research, chiefly in heart disease.

a tranquilizer with
particular usefulness in
functional disorders

TybatranTM
(pronounced TYE-buh-tran)
brand of tybamate

Extensive clinical experience, including eleven double-blind studies,¹⁻¹¹ indicates that Tybatran is an effective agent for the relief of anxiety and tension. It appears to lend itself particularly well to the management of the anxious patient who "somatizes"—whose anxiety and tension find expression in complaints such as headaches,^{4,8,10,11} fatigue,⁴ insomnia,^{2,4,8,9,12} anorexia,^{3,8,9} and pruritus.⁷

Two salient features seem to set Tybatran somewhat apart from certain other commonly used tranquilizers.

1. Tybatran often proves more effective than meprobamate and chlordiazepoxide. In one study,⁴ severe anxiety responded more effectively to tybamate than to meprobamate; in another,⁸ symptom-response superiority of tybamate over chlordiazepoxide was marked at statistically significant levels of confidence.

2. Tybatran appears to be less sedating than other widely used tranquilizers. Side reactions are relatively infrequent; when they do occur, they may take the form of drowsiness, although insomnia, ataxia and other adverse effects have been reported. Nevertheless, Tybatran impresses many clinicians by its comparative lack of undesirable sedative action.^{3,6,12,13} (If drowsiness or vertigo is present, activities requiring optimal alertness should be avoided.)

For patients in whom anxiety is manifested in any of a multiplicity of physical complaints, Tybatran deserves a clinical trial. These are the challenging patients, those with recurrent, persistent, ever-changing symptoms for which there is no clinical or laboratory evidence of organic disease.

Usual adult dose: one or two 250 mg. capsules 3 or 4 times daily. Adjust to suit individual requirements.

A-H-ROBINS

Prescribing Information

Dosage and administration. The suggested adult dose of Tybatran (tybamate) is one or two 250 mg. capsules three or four times daily. Dosage should be adjusted to suit individual requirements. While clinical experience with Tybatran (tybamate) in children has been very limited to date, the recommended daily dosage for children 6 to 12 years old is 20 to 35 mg./kg. body weight, in three or four equally divided doses. Dosage should be adjusted to suit individual requirements. Until further clinical experience is obtained, administration of Tybatran (tybamate) to children under 6 years of age is not recommended. Daily doses larger than 3000 mg. are not recommended, although in a few instances doses in excess of this figure have been administered. Tybatran (tybamate) is also available in 350 mg. capsules, for convenience in dosage adjustment, e.g., one capsule three times daily and two at bedtime.

Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

(pronounced TYE-buh-tran)

TybatranTM

brand of tybamate

a tranquilizer with
particular usefulness in
functional disorders

Prescribing information continued from preceding page.

withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

Supply. Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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A-H-ROBINS A. H. ROBINS COMPANY, RICHMOND, VA. 23220

Asthma Panel

(Continued from page 185)

not respond to adrenalin the way normal people do and that this is why their own adrenalin fails to open up their bronchial tubes. New forms of treatment can be expected in the not too distant future when more is understood about the biochemical and physiological mechanisms that lead to asthma."

Patients scheduled to undergo major surgery can benefit significantly from a new six page pamphlet, "Anesthesiology," developed by the AMA. By letting the patient, or parents of juvenile patients, know what to expect, it can do a great deal to overcome fears or apprehensions.

The pamphlet points out the important roles of anesthesia in surgery and its advantages. Common ways of administering anesthetic drugs are enumerated. Parents are given sound suggestions on how to discuss anesthesia and surgery with children scheduled to have operations.

"Anesthesiology" is available from the AMA Order Department. Single copies are 10 cents. When ordered in quantities of 100-499 copies, it is available for five cents a copy.

Amniocentesis

(Continued from page 172)

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"I should handle prospects differently—why can't I be more forceful and get the orders!"

Too often, a chronic worrier relives the events of the day at night, when anxiety exaggerates them even more. Unable to relax physically or mentally, the patient is trapped by anxiety-induced insomnia, robbed of the restoring sleep he needs to meet the next day.

Librium (chlordiazepoxide HCl) 10 mg *h.s.* usually affords sufficient relief of anxiety and tension to interrupt the debilitating anxiety-insomnia cycle, while a t.i.d. dose helps provide excellent daytime control. On proper maintenance dosage, there is seldom any undue interference with mental acuity or physical coordination. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See prescribing information.)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures neces-

**for anxiety-
induced insomnia**
Librium®
(chlordiazepoxide HCl)
one cap. t.i.d. plus h.s.

sary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

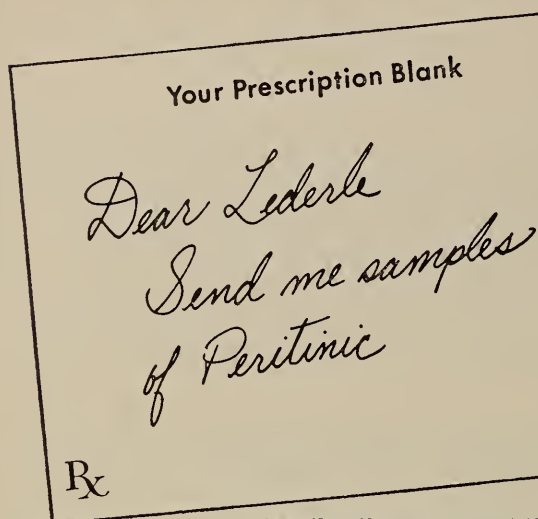
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anticoptive, *adj.* (*anti* opposed to
+ *costive* causing constipation.)
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ing hematinic?)

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Hematinic with Vitamins and Fecal Softener

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● Elemental Iron (as Ferrous Fumarate) .	100 mg
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Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

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MEETING MEMOS

Feb. 19—The Chicago Society of Allergy will meet at the Blair House Restaurant, Chicago. Guest speakers will be Richard W. Reilly, M.D. and Somner Kraft, M.D. from the University of Chicago. The program will cover "Immune and Non-Immune Aspects of Gastrointestinal Function."

Feb. 28—"Aesthetics, Economics, and Medical Care" is the subject of the Michael Reese Hospital Annual Greensfelder lecture. Speaker will be Albert J. Stunkard, M.D., Professor and Chairman, Department of Psychiatry, University of Pennsylvania.

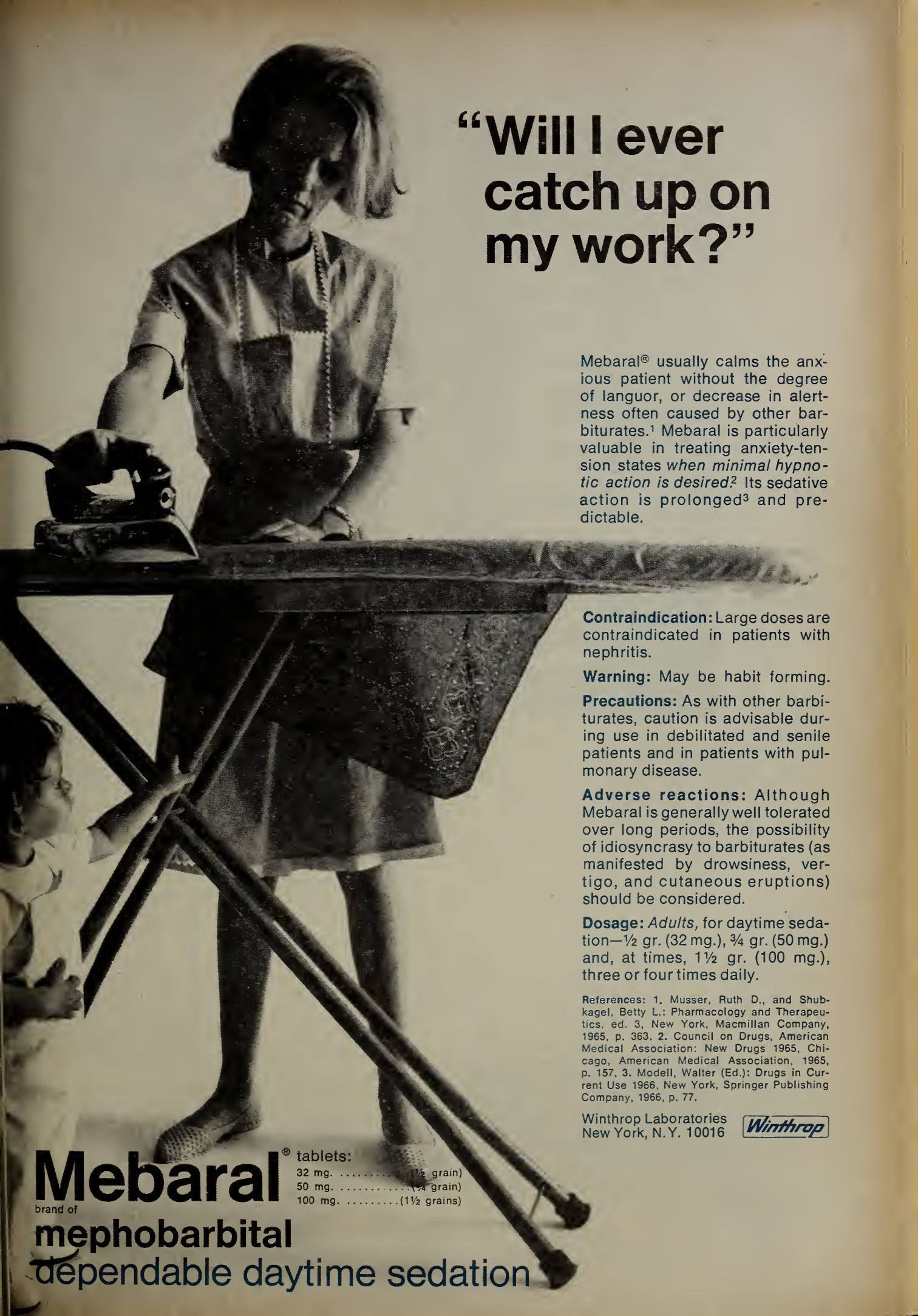
Feb. 28-29—"Advances in Pediatrics" is the topic of a post-graduate seminar sponsored by the Cleveland Clinic Educational Foundation, Cleveland, Ohio. Six guest speakers, with the 16 participating faculty members will present 25 principal topics. Registration is \$40.

Mar. 6-7—A post-graduate continuation course on the subject "Controversies in Urology" is to be presented by the Cleveland Clinic Educational Foundation. The principal topics will be "Controversies in the Management of Genitourinary Neoplasms," "Management of Infertility with Emphasis on the Male," "Controversies in the Diagnosis and Management of Obstructive Uropathy," and "What's New in Hypertension."

Mar. 15-17—A National Health Forum is to be held in Los Angeles. Quality in health care will be the theme and the sessions will be held at the Statler-Hilton. The Forum will bring together leaders in the health professions and allied fields to assess standards and procedures for assuring quality in health care services. Proposals for strengthening these will also be considered. Samuel R. Sherman, M.D., San Francisco, is chairman of the Planning Committee. This is the 16th in a series sponsored by the National Health Council.

Mar. 18-20—The American Academy of Pediatrics' annual spring session will be held in Atlanta, Ga. More than 3,000 pediatricians and guests are expected. The scientific program will include presentations on the current status of virus cancer relationships, diagnosis and management of the child who is too short or too tall, the obese child, advances in therapeutics, cur-

(Continued on page 204)



**“Will I ever
catch up on
my work?”**

Mebaral® usually calms the anxious patient without the degree of languor, or decrease in alertness often caused by other barbiturates.¹ Mebaral is particularly valuable in treating anxiety-tension states *when minimal hypnotic action is desired*.² Its sedative action is prolonged³ and predictable.

Contraindication: Large doses are contraindicated in patients with nephritis.

Warning: May be habit forming.

Precautions: As with other barbiturates, caution is advisable during use in debilitated and senile patients and in patients with pulmonary disease.

Adverse reactions: Although Mebaral is generally well tolerated over long periods, the possibility of idiosyncrasy to barbiturates (as manifested by drowsiness, vertigo, and cutaneous eruptions) should be considered.

Dosage: *Adults*, for daytime sedation—½ gr. (32 mg.), ¾ gr. (50 mg.) and, at times, 1½ gr. (100 mg.), three or four times daily.

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Mebaral® tablets:
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TROCINATE® 400 MG.
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The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

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Manufacturers of ethical pharmaceuticals since 1856



Meeting Memos

(Continued from page 202)

rent status of radioisotope scanning in children and recent advances in the diagnosis of cystic fibrosis.

Mar. 20—The first Annual Conference on Suicidology will be held at the Conrad Hilton Hotel, Chicago. One especially interesting feature of the program will be a "reconvening" of the famous 1910 Viennese symposium "On Suicide." Three additional symposia are scheduled: "Self-Destruction and the Problem of the Will," "The Current Scene: Suicide Prevention Activities in the United States," and "Reports on Current Research in Suicide and Suicide Prevention." These meetings will precede those of the American Orthopsychiatric Association.

The World Medical Association, Inc.

Membership in The World Medical Association, Inc., a tax-exempt organization representing over 700,000 doctors in some 60 countries, is now open to all members of the AMA on an individual basis. Now in its 21st year, the association is a federation of national medical associations, calling itself "the international voice of organized medicine."

It is not connected with the World Health Organization (WHO), a specialized agency of the United Nations. Instead, it represents free, professional medical associations and physicians, whereas the WHO represents the governments of many lands.

The 21st World Medical Assembly was held on Sept. 10 to 17 in Madrid, Spain. For the first time members of national medical associations attended as individual associate members, a status which is now available to all members of the AMA. Dues are \$10 per year, and this includes a subscription to "World Medical Journal" as well as the privilege of participation in the world assembly each year. Application for individual membership may be made in the form of a letter to the WMA Headquarters Secretariat, 10 Columbus Circle, New York, N.Y. 10019.

Sydney, Australia, will be the site of the 1968 Annual Assembly, while Paris, Toronto, and Amsterdam have already been selected for succeeding years. Information regarding the 22nd annual meeting will be mailed to all applicants.

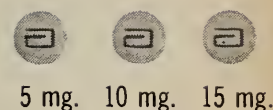
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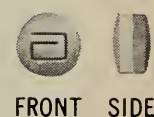
*For smooth appetite
control plus mood
elevation*

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Methamphetamine Hydrochloride
in Long-Release Dose Form

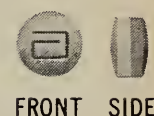


*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

801444

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

Coexistent Infections in Tuberculous Patients Respond Rapidly to Lincocin

Good to excellent response was obtained in 44 out of 49 tuberculous patients given Lincocin (lincomycin, Upjohn) to combat coexistent infections—often a serious problem for both staff and patients in the treatment of tuberculosis and other chronic diseases.

Researchers in the Sanatorium Division of Boston City Hospital and Boston University School of Medicine reported these results of a study conducted specifically to evaluate the relatively new antibiotic in such cases.

The predominant organisms cultured were *Staphylococcus*, *Streptococcus*, *Pneumococcus*, *Neisseria* and *Klebsiella*, according to Dr. Victor Lorian, Director of Laboratories and Research, and his colleagues.

"Sixteen patients had excellent results following the administration of lincomycin. Good results were obtained in 28, and only five were recorded as having poor results," the Boston group reported in *Clinical Medicine**.

All except three of the patients were receiving concomitant therapy with various combinations of antituberculous drugs; eleven had previous antibiotic therapy for their coexistent infections.

In 12 patients, the organisms cultured before treatment were absent after treatment. Ten of these patients with bacteriological cure showed rapid response of clinical symptoms; clinical response was slower in two others.

Thirty others not cured bacteriologically experienced rapid clinical improvement as evidenced by drops in temperature and white blood count and the disappearance of symptoms.

The antibiotic, developed in research laboratories of The Upjohn Company, produced only one major side effect—diarrhea in five of the 49 patients—according to Dr. Lorian.

Thirty-seven patients were given two grams of Lincocin per day and 10 received four grams per day. The treatment period varied from two days to 39 days and averaged 11 days for the group.

*74:53-54, August, 1967

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"Marie Antoinette." An early steel engraving.

She never lost her head as a hostess. She soothed her guests' tensions with wine, mankind's first medicine and the supreme mild tranquilizer for the past 5,000 years or more.

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Here's to you, Doctor, your family and your patients. Happier days with wine!

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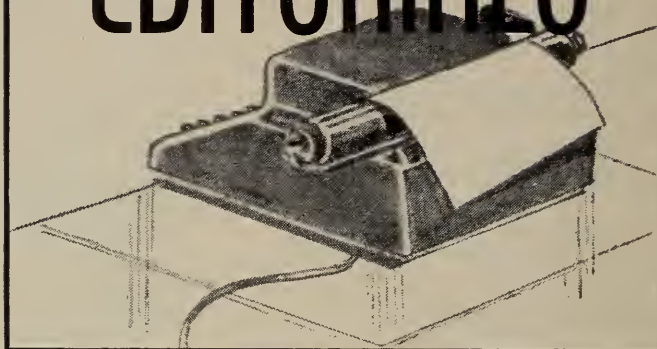


*Rx WINE: 4 ounces with lunch and dinner daily. Wine stimulates gastric flow; can help the convalescing patient; can aid the patient lacking appetite; can help relieve anxiety; can help patients suffering from the malabsorption syndrome; helps hospital and geriatric home morale; helps to make meal-time pleasant and relaxing.

Just address WINE ADVISORY BOARD, 717 Market Street, San Francisco 94103, on your professional letterhead. You will receive, free: "USES OF WINE IN MEDICAL PRACTICE" (62 pp.), and "CALIFORNIA WINE COOKERY AND DRINKS," (24 pp.) to help wine enjoyment and entertainment.

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EDITORIALS



ALCOHOLISM ON DEATH CERTIFICATES

Alcoholism is a major contributory factor in death resulting from accidents, suicide, homicide, cirrhosis of the liver, heart disease, psychiatric disturbances, and neurological disorders. Alcoholism per se may not appear on death certificates for obvious reasons. In one study, it was found to be the underlying cause of death in 129 per cent more patients than reported.

The effects of alcohol upon the body and in different individuals vary. In small doses, it affects the mood and has a toxic reaction when taken in excess. In addition, its frequent use may lead to addiction which encourages an insidious and progressive increase in the quantity consumed, with a corresponding increase in ill effects. In other words, there are many health facets to the drug.

Thompson,¹ a Los Angeles psychiatrist, reflects on the problem in these words: "Perhaps no individual sees the deplorable effects of alcoholism more than the psychiatrist. As a physician he stands beside the autopsy table and looks at the subdural haematoma of the young man who died following an alcoholic bout. In court he listens to the tales of crime and violence committed under the influence and effect of alcohol; as a doctor, he hears of and witnesses traffic accidents and his pessimism deepens as he realizes the tremendous and devastating ravages that this disorder

causes. He is appalled by the death and destruction it leaves in its wake. Finally, as a logician, he realizes that such a widespread disease or disorder is a formidable enemy indeed but that it has causes that can be discovered. Then as a scientist, he begins to seek these causes."

Determination of the blood alcohol level is most useful in establishing the relationship between the amount consumed and the real cause of death. These tests can be done anti- or postmortem. A level of 0.50 per cent or more is fatal within a short time or produces sufficient brain damage to cause death within hours. Levels of less than this are graded according to stages of intoxication that vary from being "silly" to stuporous.

It is highly probable that if more blood alcohol tests were performed on fatalities from traffic accidents, burns, falls, various misadventures, and suicide, the total mortality from alcohol could be established. We know that it is responsible for 50 per cent of deaths from motor vehicle accidents. Breathalyzers should be used more often with traffic offenders. The drinking habits of many cardiac patients may also offer clues as to why the life span of the chronic alcoholic is reduced 10 to 15 years. Those on skid row usually succumb to malnutri-

(Continued on page 219)

Clinics for Crippled Children

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 22 general clinics providing diagnostic, orthopedic, pediatric, speech and hearing examinations along with medical, social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 5, Alton General—Alton Memorial Hospital
March 6, Carmi—Carmi Township Hospital
March 6, Hinsdale—Hinsdale Sanitarium
March 7, Sterling—Community General Hospital
March 7, Carrollton—Boyd Memorial Hospital
March 7, Effingham General—St. Anthony Memorial Hospital
March 7, Peoria Cerebral Palsy (A.M.)—Zeller Zone Center
March 8, Chicago Heights Cardiac—St. James Hospital
March 12, East St. Louis—Christian Welfare Hospital
March 12, Peoria General—Children's Hospital
March 13, Champaign-Urbana—McKinley Hospital
March 13, Joliet—St. Joseph's Hospital
March 14, Macomb—McDonough District Hospital
March 14, Sparta—First Baptist Church Educational Building
March 14, Springfield General—St. John's Hospital
March 20, Evergreen Park—Little Company of Mary Hospital
March 20, Jacksonville—Passavant Hospital
March 21, Decatur—Decatur & Macon Co. Hospital
March 21, Elmhurst Cardiac—Memorial Hospital of DuPage County
March 22, Chicago Heights Cardiac—St. James Hospital

March 26, Danville—Lake View Hospital
March 26, Belleville—St. Elizabeth's Hospital
March 26, Peoria General—Children's Hospital
March 27, Rockford—St. Anthony's Hospital
March 27, Centralia—St. Mary's Hospital
March 27, Springfield Cerebral Palsy (P. M.)—Diocesan Center
March 27, Elgin—Sherman Hospital
March 28, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Editorial

(Continued from page 210)

tion or pneumonia even though their drinking plays a most important role.

In Australia, alcohol is the sixth most common cause of death and accounts for almost 3 per cent of the mortalities. Continued drinking can lead to death from delirium tremens, dementia, cirrhosis of the liver, acute and relapsing pancreatitis, beriberi, cardiomyopathy, or malnutrition. But unless alcoholism is plainly stated on death certificates, the main contributing cause never reaches the statistician.

T. R. Van Dellen, M.D.

-
1. Thompson, G. N.: "The Psychiatry of Alcoholism," in "Alcoholism," edited by Thompson, G. N., Thomas, Springfield: 452.

Do you have patients who try to hide fear behind bravado?

They may be unable to face the pain of their depression. The head, the manner, the posture may shout security, success, and a leadership born of intellect. But it's all a cloak designed to cover failure, and the underdeveloped ego threatens to topple the overlarge frame.

You see many depressed patients who hide their real anxieties behind a smoke screen of pretense. The more they try to conceal reality, the more entrenched the disturbances become. The role they assume is not adequate to suppress their inner turmoil. Unchecked, the turmoil finds expression in other symptoms.

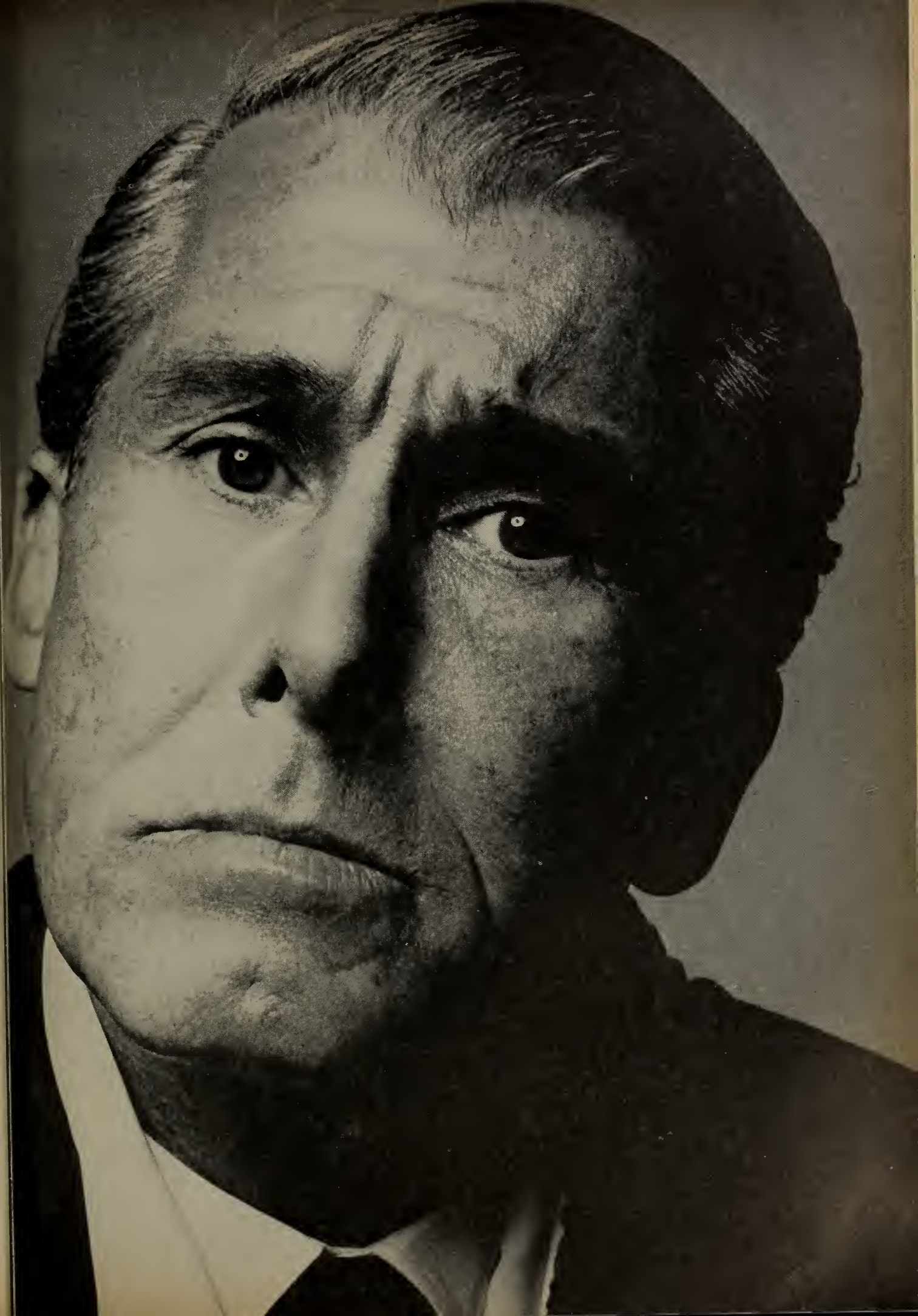
They want your help and Aventyl HCl can help you. Whether depression is open or secretive, Aventyl HCl assists you in relieving the symptoms and the state of depression itself. It may aid in removing the emotional distortions and, in lifting the depression, help patients face, accept, or change their life patterns.

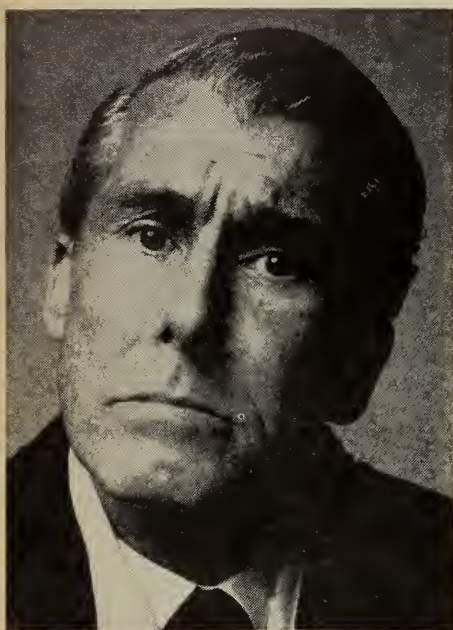


Eli Lilly and Company
Indianapolis, Indiana 46206

Helps remove the symptoms,
lift the depression,
and release the patient

Aventyl[®] HCl
Nortriptyline Hydrochloride





Aventyl® HCl

Nortriptyline Hydrochloride

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two months after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by

the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl

HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily

10 mg.—Ages three to six, 1 Pulvule one to three times daily

Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily

Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid, 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [101245]

Additional information available to physicians upon request.



Eli Lilly and Company
Indianapolis, Indiana 46206

Who Shall Live, Who Shall Die

By J. ERNEST BREED, M.D.

The increasing ability to keep the body tissues alive after death by artificial means present new problems in ethics to the medical profession. How long must such measures be continued? Does the physician commit murder when he turns off the respirator, or fails to replace the pacemaker battery?

The mores of a society have long been in the domain of the church, so ethical and moral problems presented by the abnormal prolongation of life are of concern to the Illinois State Committee on Religion and Medicine.

Fred Rosner, M.D., writing in last year's October 23 issue of the *Journal of the A.M.A.* stated that traditional Christian moralists draw a distinction between "ordinary" and "extraordinary" medical or surgical procedures. A patient is not bound to submit to extraordinary treatment (very costly, very painful, very difficult, or very dangerous) nor is the doctor bound to apply such extraordinary treatment in cases where the patient cannot be consulted. He also stated that in the last year of his life, Pope Pius XII issued an encyclical not requiring physicians to use "extraordinary" measures when certain death and suffering lie ahead.

In discussing other religious attitudes Dr. Rosner stated that in the Protestant churches there exist all possible colors in the spectrum of attitudes toward medical intervention in relation to termination of a patient's life. The Jewish attitude, quoted from Isadore Jacobovits, is summarized by "Any form of active intervention is strictly prohibited and condemned as murder and anyone who kills a dying person is liable to the death penalty as a common murderer. At the same time, Jewish law sanctions the withdrawal of any factor whether extraneous to the patient himself or not, which may artificially delay his demise in the final phase."

We desperately need a definition of "death." In the past we would consider a person dead if his heart stopped beating or if he stopped breathing. Often today these symptoms can be successfully treated. Frank J. Ayd, M.D. defines "clinical death" as that time spontaneous breathing has ceased and the heart has stopped beating and "biological death" as death of the tissues. Tissue cells may remain viable for several hours after clinical death. The French Academy has ruled that a person is legally dead when his brain has ceased to function. Throughout the world a flat brain wave on encephalographic tracings is gradually being advanced as the most reliable evidence of "clinical death."

The death concept is becoming increasingly important as organ transplantation becomes more common. Organs must be alive when transplanted, yet to take the heart or a liver from a person who is not "clinically dead" would indeed be murder. Who can say with certainty that a patient is moribund and therefore fair game for those seeking spare parts? Is it morally right to resuscitate one who is "clinically dead" and keep him alive by artificial means until his organs can be removed for transplantation? If so when does he die, before resuscitation by artificial means, or after they are stopped?

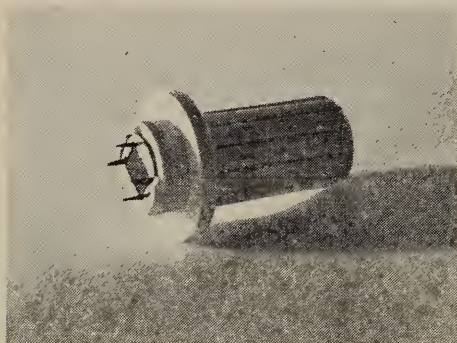
The legality of organ transplantation must be clarified. Some states have legalized the procedure, some have laws against it and most state legislatures have never considered the problem. The American Bar Association is working on a measure which may soon be introduced into many state legislatures.

The responsibilities heaped upon the physician are becoming more and more significant. Life or death often will depend

(Continued on page 224)

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN, TINE TEST

(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



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Hormones Will Play An Important Role In Treating Ulcer, Scientist Predicts

The pituitary, adrenal and sex hormones play a significant role in development of peptic ulcer and eventually will have a place in its treatment—and perhaps prevention.

This prediction has been made by a research scientist who said the old dictum “no acid in the stomach, no ulcer” may still be true, but actually is an oversimplification of the extremely complex causes of peptic ulcers.

The influence of the pituitary hormones upon formation of the protective mucus lining of the stomach may be one of the most vital factors in determining whether an individual develops the disease, according to Dr. Andre Robert, senior scientist, Metabolic Disease Research, The Upjohn Co.

At a recent conference in Canada honoring Dr. Hans Selye, director of the Institute of Experimental Medicine and Surgery at the University of Montreal and the man who coined the word “stress” in the mid-1930's, Dr. Robert reviewed the whole range of ulcer research over the past three decades.

He commented that both psychological factors (stress) and the hormones “play an
(Continued on page 225)

Medicine and Religion

(Continued from page 223)

upon immediate “value judgments.” What are the patient's chances to live if heroic measures are used and how long might his extended life last? What will be the cost in terms of suffering by the patient, finances and sacrifices by the family? How long should resuscitative measures be continued? Should organ transplant be attempted? What of the donor and his rights?

New medical discoveries provide new perimeters and raise innumerable questions of ethics. Physicians should present the problem and enter into the discussion but the public at large must ultimately decide what is ethical and what is legal. Until then physicians must proceed by the general rule laid down by Hippocrates 2500 years ago. In his oath appear the words, “I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patient, and abstain from whatever is deleterious and mischievous.”

OBITUARIES

***Dr. William W. Bauer**, a former director of the bureau of health of the American Medical Association, died Dec. 25 at the age of 75.

Dr. George Campbell, a retired Flora physician, died Nov. 19 at the age of 82.

***Dr. Cornelius M. Mann**, Chicago, died Dec. 5 at the age of 63. He was a founder of the Vaughn Medical Group and was a member of the American College of Surgeons and the Illinois Surgical Society.

***Dr. Frank M. Davis**, a prominent Springfield surgeon for 34 years, died Nov. 30 at the age of 72. He was a member of Sangamon County TB Association, past president of the Sangamon County Medical Society, past vice president of the Down State American College of Surgeons and past chairman and secretary of the United Community Services.

***Dr. Thomas P. Foley**, a physician for 60 years, died Jan. 4 at the age of 84. He was a member of the staff of Oak Park Hospital for 46 years, a member of the Medical Examining Committee of the Department of Registration and Education, a member of the Fifty Year Club of ISMS and was an instructor in the medical schools at Northwestern University, Loyola University, and the University of Chicago.

***Dr. Robert M. Fonner**, a physician for 38 years, died Dec. 25 at the age of 70. He was a former member of the staff of St. Anne's Hospital, a major in the army's medical corps.

***Dr. Ewen J. Graham**, 77, Park Ridge, died Jan. 5 at the age of 77. He was a staff member of American Hospital for 30 years.

***Dr. Irwin I. Hoffman**, a former County jail physician, died Dec. 21 at the age of 75. He was on the staff of Walther Memorial Hospital and psychiatric staff at the Cook County Mental Health Clinic.

***Dr. Martin Hubrig**, a retired Elgin Physician, died Dec. 13 at the age of 78. He was a former president of the medical staff in Sherman Hospital and a member of the Sherman and St. Joseph Hospital staffs.

***Dr. Joseph F. O'Malley**, an assistant professor of orthopedic surgery at Chicago

Medical School, died Jan. 5 at the age of 68. He was a member of the House of Delegates and was serving as chairman of the Membership Committee of ISMS at the time of his death.

***Dr. Molly Robertson**, 79, a resident physician at Peoria State Hospital, died Sept. 12.

***Dr. Philip Rosenblum**, 76, died Dec. 20 in Michael Reese Hospital, where he had been a staff member since 1913. He was a member of the Fifty Year Club of ISMS.

***Dr. Manning Sankstone**, 61, a psychiatrist who was chief of staff in the Chicago State Hospital for 25 years, died Dec. 18.

***Dr. Frank Leroy Smith**, West Chicago, died Nov. 24. He served 32 years as medical director for Western Electric Company's Hawthorne Works, was a member of the Aux Plaines branch of the Chicago Medical Society.

***Dr. James D. Walsh**, River Forest, died Dec. 8. He was a member of Illinois Ophthalmological Society, University of Wisconsin Medical Alumni, Illinois Eye and Ear Alumni and staff member of Loretto, Bethany, Riveredge and St. Anthony de Padua Hospitals.

Dr. Marilyn Weinberg, Chicago, died Dec. 20 at the age of 35.

***Dr. Morris D. Yampolski**, a physician and surgeon who had been practicing in Roseland for 50 years, died Dec. 19 at the age of 75. He was a member of the Fifty Year Club of ISMS.

***Member of the Illinois State Medical Society.**

Hormones (*Continued from page 224*)
important role" in the development of ulcers.

"On a statistical basis, ulcer patients have been found to be of a characteristic personality type. They are usually tense and exhibit an infantile oral craving to be loved, to be fed," he said.

Reviewing Upjohn's work with hormones, Dr. Robert reported that ulcers have been induced experimentally by giving large doses of the steroid prednisolone to fasted animals. In these studies, removal of the pituitary gland prevented formation of

(*Continued on page 226*)

Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093—Telephone (312) 446-8440.

Hormones

(Continued from page 225)

steroid-induced ulcers. Then, sensitivity to such ulcers was restored by administering either of two pituitary hormones—ACTH (adrenocorticotropin) or TSH (thyroid-stimulating hormone). ACTH decreased production of protective mucus in the stomach lining.

It was also discovered that a third pituitary hormone, STH (somatotropin) prevented ulcer formation while paradoxically increasing the secretion of stomach acid. Dr. Robert speculated that this might occur because STH also increases mucus production, thereby making abundant newly formed mucus available to counteract gastric acid.

Removal of both the pituitary and adrenal glands produced evidence that the pituitary hormones are actually “messengers” which induce the adrenals to secrete hormones affecting mucus cell production, Dr. Robert reported.

“Enough is already known about the interaction of hormones in peptic ulcer to suggest that they will eventually have a prominent role in its treatment,” he commented.

Dr. Robert noted that in pregnancy, when hormone production is at a high level, women rarely develop ulcers and, where a woman already has an ulcer, it always regresses during pregnancy. On this basis, some clinical investigators have administered estrogens (female sex hormones) to ulcer patients with a large degree of success, he said.

Older treatment methods generally attack the symptoms—not the causes. Usually they include bland diets (large amounts of milk and cream), antacids, nerve blockers, and sometimes tranquilizers.

Although ulcers do not form unless acid and pepsin are present in the stomach, the effect of pituitary hormones on mucus production must be considered a critical factor, Dr. Robert said.

He pointed out that mucus cells and their products are a natural defense against a host of irritants, including the stomach's own gastric juices, which are corrosive to unprotected tissue. A clue to the importance of the mucus cells is the fact that these are the only cells in the stomach which multiply, he added.

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*Easy on
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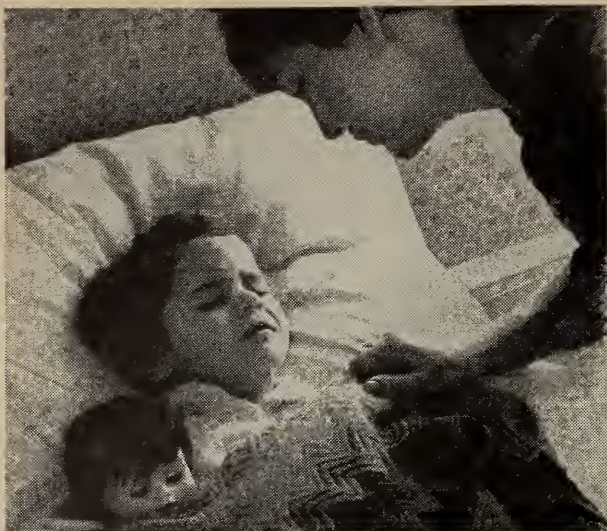
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Each fluid ounce of creamy white suspension contains:

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Contains opium (1/4 grain) 15 mg. per fluid
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Kaolin (specially purified) (85 grains) 5.5 Gm.
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NEW SINGLE CHEMICALS

MYAMBUTOL Antitubercular R

Manufacturer: Lederle Laboratories

Nonproprietary Name: Ethambutol HC1

Indications: Pulmonary tuberculosis. To be used
in conjunction with at least one other anti-
tubercular drug.

Contraindications: Hypersensitivity to the drug;
optic neuritis.

Dosage: Adults, and children over 13 years:
Initial treatment: 15 mg./kg. body weight as
single daily dose.

Retreatment: 25 mg./kg. body weight, as single
daily dose, after 60 days decrease to 15
mg./kg. body weight.

Not for children under 13 years.

Supplied: Tablets - 100 and 400 mg.

NEW SINGLE CHEMICALS

VIVACTIL HC1 Psychostimulant R

Manufacturer: Merck Sharp & Dohme

Nonproprietary Name: Protriptyline HC1

Indications: Mental depression in patients under
close medical supervision.

Contraindications: Pyloric stenosis, glaucoma,
tendency to urinary retention. Not to be given
concomitantly with MAO inhibitors, guanethi-
dine and similarly acting compounds.

Dosage: Adults - 15-40 mg., divided into 3 or 4
doses.

Dosage must be individualized.

Not for children under 12 years.

Supplied: Tablets - 5 and 10 mg., bottles of 100
and 1000.

COMBINATION PRODUCTS

ANTIBIOTIC OINTMENT Antibiotic -

Topical

o-t-c

Manufacturer: McKesson Laboratories

Composition: Each Gram contains:

Bacitracin	500 u
Neomycin Sulfate	5 mg.
Polymyxin B Sulfate	5,000 u

Indications: Prevention of infection of minor
cuts, abrasions and burns.

Contraindications: None mentioned.

Dosage: Apply liberally twice a day.

Supplied: Tubes - 1/2 oz.

COMBINATION PRODUCTS

CAQUIN Cream Corticoid—Local R

Manufacturer: Tilden-Yates Laboratories, Inc.

Composition: Hydrocortisone 1%
Iodochlorhydroxyquin 3%

(Continued on page 230)

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Graduate School of Medicine
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STARTING DATES—1968

SPECIALTY REVIEW COURSE IN SURGERY, Part II, March 4
 SPECIALTY REVIEW COURSE IN MEDICINE, Part II, March 4
 SPECIALTY REVIEW COURSE IN THORACIC SURGERY, April 1
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates

PROCTOSCOPY & VARICOSE VEINS, One Week, March 18
 ESSENTIALS OF PLASTIC SURGERY, One Week, April 1
 FLUIDS & ELECTROLYTES, One Week, April 22
 ARTERIOGRAPHY, Four Days, March 19
 ADVANCES IN FRACTURES & ORTHOPEDICS, March 11
 VAGINAL APPROACH TO PELVIC SURGERY, One Week, March 4
 GYNECOLOGY, Office & Operative, One Week, March 25
 OBSTETRICS, General & Surgical, One Week, April 1
 RADIOISOTOPES, One or Two Weeks, First Monday each month

BASIC ELECTROCARDIOGRAPHY, One Week, March 11
 BASIC INTERNAL MEDICINE, One Week, April 22
 CLINICAL NEUROLOGY, One Week, April 29
 ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

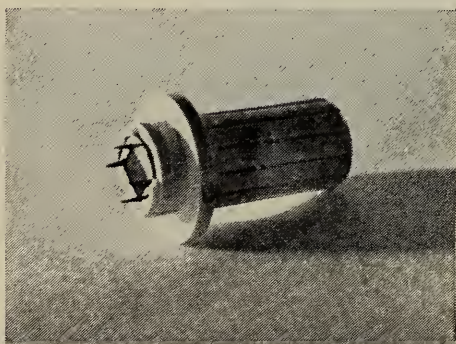
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TUBERCULIN_(Rosenthal) TINE TEST

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



330-8/6135

New Pharmaceutical Specialties

(Continued from page 228)

Indications: Dermatological disorders that may be expected to respond to corticosteroids, e.g., atopic dermatitis, contact dermatitis, impetiginized eczema, nummular eczema, infant and adult eczema, neurodermatitis, non-specific pruritus ani and vulvae.

Contraindications: Not for use in tuberculosis of the skin, viral conditions of the skin, or in patients with known iodine sensitivity.

Dosage: Apply topically, 3 or 4 times daily.

Supplied: Cream - package not specified.

DIACOF Cough Preparation

o-t-c

Manufacturer: Madland Laboratories

Composition: Each 5 cc. contains:

Dextromethorphan HBr	7.50 mg.
Chlorpheniramine Maleate	0.75 mg.
Glyceryl Guaiacolate	25.00 mg.
In an artificially sweetened, peach-flavored base.	

Indications: Relief of cough, and common cold and hay fever symptoms, specially formulated for diabetics.

Contraindications: None mentioned.

Dosage: Adults - 1 or 2 tsp., every 4 hours.

Children 6 to 12 years - ½ of the maximum adult dose. Not for children under 6 years. Do not exceed four doses per 24 hours.

Supplied: Bottles - 16 oz. and 1 gallon.

COMBINATION PRODUCTS

DRALSERP Hypotensive

R

Manufacturer: Lemmon Pharmacal Co.

Composition: Hydralazine HCl 25mg.
 Reserpine 0.1 mg.

Indications: Moderate to severe hypertension, and certain cases of malignant hypertension.

Contraindications: Aortic insufficiency.

Dosage: Two tablets 4 times a day, later decreased to one tablet q.i.d.

Supplied: Tablets - bottles of 100 and 1000.

2G/DM Cough Preparation

o-t-c

Manufacturer: Pitman-Moore

Composition: Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Dextromethorphan HBr	15 mg.

Indications: Symptomatic relief of non-productive coughs.

Contraindications: None mentioned.

Dosage: As indicated.

Supplied: Bottles - 4 fluid ounces.

NORQUEN Progesterone/Estrogen Comb.

R

Manufacturer: Syntex Laboratories

Composition: Mestranol 0.08 mg.
 (14 white tablets)

Mestranol	0.08 mg.
Norethindrone	2.0 mg.

(6 blue tablets)

Indications: Oral contraception, sequential.

Contraindications: Thrombophlebitis, or history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breast or genital organs, undiagnosed vaginal bleeding.

Dosage: Starting on day 5 of menstrual cycle, one white tablet for 14 days, then followed by one blue tablet for 6 days.

Supplied: Tablets - packages of 20 and 60.

BLUE SHIELD REPORT

JAN 17 '69



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 3

March, 1968

BC-BS New "65-Plus" Program to be Offered

A new program designed to supplement in full the benefits of Medicare will be offered to individuals over-65 in Illinois next month.

Our new "65-Plus" program will provide greater dollar benefits. It will also simplify claims processing since it eliminates problems with the deductibles and co-insurance which are confusing to some elderly beneficiaries.

What will our new "65-Plus" program cover? Regardless of the status of the subscriber's \$50.00 Part B deductible, the new Blue Shield plan will pay 20% of the physicians' Usual and Customary charges for the full Medicare scope of medical and surgical services for hospital bed patients. It will pay 20% of the physicians' usual and customary charges for visits to certificate holders in extended care facilities while the member is receiving medicare benefits. It will pay 20% of the physicians' usual and customary fee for surgical services and accident care in the doctor's office or in the out-patient department of the hospital.

Blue Cross will pay the initial \$40.00 hospital deductible; the daily \$10.00 co-insurance payment required from the beneficiary from the 60th day to the 90th day; the \$20.00 daily co-payment after the 90th day and for 730 additional days if necessary; and the \$5.00 per day beginning the 21st day in an extended care facility and through the 100th day. In addition, hospital out-patient charges for medical emergencies, accident care, and ambulatory surgery will be paid in-full.

The superior "65-Plus" program will be offered to all new subscribers over age 65 replacing the present Major Medical program. Our present non-group certificate holders will be offered an opportunity to switch to the new program. Mailings will begin in April.

In addition to being broader in its scope of coverage, the new "65-Plus" program (by eliminating problems with the \$50.00 deductible) should increase the speed in which claims can be processed.

Because of the broader scope of coverage and more dollar benefits the cost of the new program will be slightly higher than the current Series-65 Major Medical certificate. Advertising and promo-

524 New Groups Subscribe to Blue Shield

In 1967, 524 companies enrolled their employees in Blue Cross-Blue Shield. The range is broad and varied and include industries from heavy steel to small fabricating plants . . . from commercial institutions to the Catholic Archdiocese of Chicago . . . from municipalities to travel agencies . . . from laboratories to data processing companies.

Almost as varied is the number of employees in these groups—from 4 to 7,500 and the type of Blue Shield benefits reflects the desires of the individual groups governed, of course, by the amount of money they are willing to pay for their individual benefit programs.

Over the years, Blue Shield programs have been developed to meet the changing needs of the public and their health care financing. Today there is a Blue Shield plan to fit every need—from the less expensive General Certificate to the more expansive H-300, the I-450, the new Usual and Customary program, and the \$10,000 Major Medical plan, with numerous riders available to cover a variety of specific benefits.

It's been said before—there is no bargain basement in health care protection . . . people get what they pay for.

Every day more groups are graduating to the broader, expansive Blue Shield benefit programs.

It's the consensus of Blue Shield groups that providing Blue Shield protection for employees is an added inducement in attracting and keeping good personnel.

(BC-BS "65-Plus" Program continued)

tion for the new "65-Plus" program will commence shortly.

We are happy to report also that steps have been taken to offer Blue Cross-Blue Shield programs to individuals over 65 who are ineligible for Medicare.

These plans for senior citizens are in response to changing market conditions and to additional demands made on private health care financing. We also feel that these programs respond to requests made by physicians to provide a variety of choices in health care protection on a voluntary basis.

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Time Limits Established for Filing Part B Claims

Time limits for filing Medicare Part B claims were established by the 1967 Social Security amendments.

Claims must be submitted to the carrier (Blue Shield for the counties of Cook, Kane, Lake, Will and DuPage) no later than the end of the calendar year following the year in which the services or supplies were provided. Services and supplies provided in the last three months of any calendar year are considered to have been provided in the following year. This provision is consistent with the deductible "carry-over" feature, whereby expenses credited to the beneficiary's deductible in the last three months of the year may be counted toward his deductible for the following year.

Claims for covered services and supplies received by a beneficiary during the first three months of Medicare—July, August, and September, 1966—must be submitted to the carrier not later than March 31, 1968.

Patient's Signature on Assigned Claims

Some patients have challenged assigned payments to physicians, especially hospital-based physicians, stating that they did not make an assignment. It is therefore necessary that we have the patient's signature on *all* assigned claims unless a blanket SSA 1490 has been submitted for the same illness. The physician treating a patient over an extended period of time need not obtain the patient's signature each time he accepts an assignment. However, he can obtain the patient's consent to an assignment of unpaid charges for the anticipated period of treatment by having the patient sign a brief statement as follows: "I request that payments under the medical insurance program be made directly to Doctor _____ on any unpaid bills for services furnished me by that physician during the period _____ to _____." When the physician submits the 1490 for payment on which he accepts an assignment, he should indicate in the patient's signature space "This is a continuation of a course of treatment for which patient's assignment was previously obtained."

All Refraction Procedures Excluded From Coverage

Effective January 2, 1968, all refractions performed during any eye examination are excluded from coverage under Medicare Part B.

(Ask Blue Shield continued)

This exclusion applies whether the refractions are performed by ophthalmologists, other physicians or optometrists, and whether the total examination is for the treatment or diagnosis of eye disease or injury, or in connection with furnishing prosthetic lenses.

Although the original Medicare law excluded refractions performed for the purpose of prescribing, fitting, or changing eyeglasses, such procedures were covered when performed by a physician as a part of a more general examination to treat or to determine the nature or extent of eye disease or injury.


HINTS TO SPEED PAYMENTS

1. When more than one physician renders service to a Medicare beneficiary (i.e. surgeon, assistant surgeon, internist, etc.), it is necessary for us to know what service *EACH* physician provided and the fee he charged before we can process the claim. In order for us to make payment, we need this information from *EACH* physician whether he accepts an assignment or submits an itemized statement to his patient.
2. If you bill for technical surgical assistance, indicate the date of the surgery, procedure performed and the duration of surgery. If the billing is for daily medical care in addition to technical surgical assistance, itemize the billing as to the charge for daily visits, including the medical diagnosis requiring daily care, and the charge for technical surgical assistance.
3. If billing for medical care during the same hospital admission major surgery was performed by another surgeon, indicate the condition that required daily medical care, surgery performed, and describe the services fully.
4. If billing for intensive care, describe the condition and approximate number of hours in prolonged detention with the patient. Itemize charges as to the charge for daily care and the charge for intensive care.
5. When the pre-operative and/or postoperative care is provided by a physician other than the surgeon, it should be specified in *EACH* report.

IMPORTANT NOTICE:

A number of significant changes in the Medicare law occurred when the 1967 Social Security amendments were signed on January 2, 1968.

The Blue Shield Plan of Illinois Medical Service, Part B carrier for the counties of Cook, Kane, Lake, Will and DuPage, has included in this issue and the February issue of the *Blue Shield Report to Illinois Physicians* special reference to the changes that were effected January 2, 1968 and others that will become effective at later date. This bulletin is prepared so that physicians and their office assistants may better understand the changes which affect Medicare Part B. Keep your copy handy for reference.



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that the
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weight control
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OBEDRIN MENU PLAN**

A slim figure is the glamour goal of most women. In your practice, though, you undoubtedly see many women and men who should lose weight for fundamental health reasons. Your professional guidance plus Obedrin-LA and the Obedrin Menu Plan can help keep patients on your program longer. One tablet taken daily trickle-releases medication in a balanced ratio to curb appetite and sustain mood. Write for a free supply of the Obedrin 1000 Calorie Menu Plan.

DOSAGE: OBEDRIN-LA—1 daily, usually at 10 a.m. OBEDRIN Tablets and Capsules—1 tablet or capsule at 10 a.m. and 3 p.m. If necessary to suppress late evening hunger, another tablet or capsule may be taken at 8 p.m. OBEDRIN tablets are grooved so a half tablet can be taken if it is found sufficient for appetite control.

SUPPLY: OBEDRIN-LA—Tablets, two-layer in bottles of 50 and 250. OBEDRIN—Tablets in bottles of 100, 500 and 1000; Capsules in bottles of 100 and 1000.

Caution: Federal law prohibits dispensing without prescription.

CAUTION: Should not be given concurrently with monoamine oxidase inhibitors. It should be used with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

SIDE EFFECTS: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage.

"Trickle-Release" Tablets

Obedrin®-LA

Each tablet contains: Methamphetamine HCl, 12.5 mg.; Pentobarbital, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg.

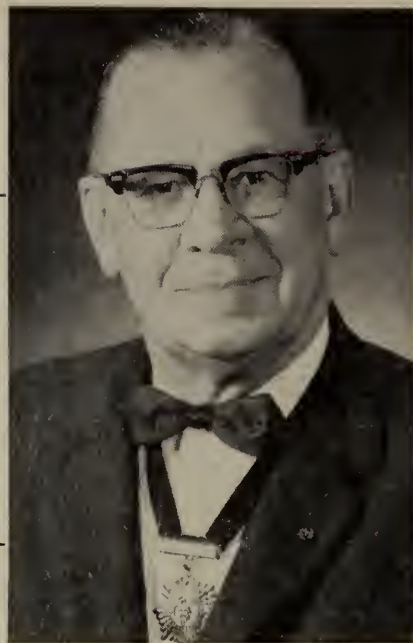
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The president's page



Newton DuPuy, M.D.

LEADERSHIP. According to Webster's this is a noun used to denote "the state of being a leader." And a leader is one who leads, guides, directs, conducts or influences in any capacity.

As scientifically trained professional persons we are asked for advice and looked to for guidance. But this is not only with respect to medicine. Our opinion is respected and sought out in many areas of concern. It is imperative that we maintain an awareness of current activities outside the field of medicine. We must do this if we are to maintain a position of leadership.

The political arena is probably going to be extremely lively this year—on the local, state and national level. It is in this area that we can and should exert some of our greatest influence. While leadership in our local, state or specialty medical societies must continue to be developed, we also have an obligation to become leaders on the political scene. We must become informed and eclectic in our consideration of the issues presented. Actions and decisions of our elected representatives and officers may affect our lives and livelihood. We must play a significant contributory role in the selection of our public officials so they may become informed about the apparatus known as organized medicine.

A unique opportunity will present itself on April 7. This is the annual Leadership Conference to be held at the St. Nicholas Hotel, Springfield. All county medical society presidents, presidents-elect, secretaries, treasurers, executive directors, editors and

ISMS delegates, (as well as the ISMS and Woman's Auxiliary Committee chairmen) will benefit by attendance. Our Leadership Conference brings together key individuals to discuss the latest and most authoritative answers to questions of vital concern. All ISMS members are urged to attend.

Scheduled to speak at the evening dinner is Senate Minority Leader Everett M. Dirksen. His appearance indicates the significance of the meeting. Also part of the day-long program will be: a panel of U.S. and Illinois Department of Public Health officials discussing "Comprehensive Health Planning" legislation—its ramifications; "Health Manpower Problems," presented at the noon luncheon by AMA president-elect Dwight L. Wilbur, M.D., and ISMS president-elect Philip G. Thomsen, M.D., as one of the afternoon speakers on "Elections '68." Washington columnist Robert D. Novak, co-author of the syndicated Evans-Novak *Inside Report*, and a panel of four Illinois congressmen will complete the program.

If you study the word *leadership* you will find that over 300 words of four letters or more may be formed from the component letters (excluding plurals and proper nouns). But if you take part in leadership in the broadest context you will find a personally rewarding experience and a sense of pride in your role.

Your attendance at the Conference is vital not only to our profession but to the public.

Abstracts of Board Actions

January 20-21, 1968

BOARD SEEKS CLARIFICATION OF "EMERGENCY SERVICE"

ISMS Legal Counsel Frank Pfeifer has been asked to provide the Board of Trustees with a legal definition of "emergency service." The action follows complaints from members that they frequently are asked to leave an office full of patients to provide immediate hospital emergency room service to persons whose problems are minor. After consultation with Dr. Franklin D. Yoder, Director of the Illinois Department of Public Health, Mr. Pfeifer will attempt to clarify the legal responsibilities of physicians under Illinois law and under the rulings of the Joint Commission on Accreditation of Hospitals, including how soon the physician must be in the hospital emergency room, whether or not he must leave his office and under what circumstances he must serve.

EXAMINATIONS FOR "FITNESS TO PRACTICE"

The 1968 House of Delegates will be asked to adopt a concept of voluntary participation in a program to keep members abreast of advances in medical knowledge. The Board is concerned about the possibility of state and/or federal governmental agencies instituting programs of medical re-examination or re-licensure.

COMMITTEE TO EVALUATE MAIL ORDER LABORATORIES

The Laboratory Evaluation Committee has been asked to study the problem of out-of-state mail order laboratories. Trustee James B. Hartney, M.D., a former chairman of the committee, told the Board that use of out-of-state laboratories should be discouraged because of the hazards of shipment, possibilities for errors, lack of close contact, and the discouragement of better services at the local level. In addition, the ethical aspects of physicians making surcharges on such laboratory reports will be studied by appropriate committees.

REPORTS ON ISMS INSURANCE PROGRAMS

Representatives of insurance companies handling the Society's various insurance programs reported that:

1. The Retirement Investment Program, started in 1965 to protect physicians against periods of inflation through a combination group annuity and a mutual fund stock investment plan has 174 participants and a total investment exceeding \$830,000.
2. The Tax-Qualified Retirement Program (Keogh Plan), a tax-deductible savings plan has total investments of almost \$500,000 in group annuities and mutual funds.
3. The Major Medical Expense Plan, has 1,673 members insured for \$15,000 each.
4. The Group Disability Program, having 33 percent of eligible membership enrolled, has dispensed over \$2 million in disability, accident, or sick benefits.

UTILIZATION REVIEW AND THIRD PARTIES

Because Utilization Review Committees throughout the state are complaining about increasing demands for information by third parties, the ISMS Board of Trustees, on recommendation of the Committee on Hospital Relations, has adopted the following policy statement:

"Utilization Review Committees of hospitals and nursing homes are urged not to release findings to any third parties, including governmental agencies. Any reports issued by the committee should be submitted to the chief of staff for his disposition."

On learning that the federal government is demanding that hospitals submit to Medicare audits, the Board further adopted this statement:

"The ISMS recommends that audits and surveys which impinge on personal privacy, quality of patient care, and local trustee and medical staff decisions as to hospital management should be avoided."

AMBULANCE STUDY COMMISSION APPOINTED

At the request of the Illinois Funeral Directors Association, the Board of Trustees has created a five-man Ad Hoc Ambulance Study Commission. The Funeral Directors Association reports that its members, who furnish about 80 percent of the ambulance service in Illinois, are considering abandoning this work because of rising costs and Medicare complications. The ISMS Commission, composed of Dr. Max Klinghoffer, Dr. Harold C. Lueth, Dr. Colman O'Neill, Dr. James Kurtz, and Dr. William Hark will meet with representatives of the Illinois Hospital Association and the Illinois Municipal League to study the impending crisis.

TASK FORCE TO ATTACK FAMILY PHYSICIAN SHORTAGE

Upon recommendation of the Council on Legislation, the Board of Trustees will appoint a Task Force to take a position of leadership in creating more family physicians to render services in all parts of the state. The Chairman of the Board stated that this Task Force would include Dr. Jack Gibbs, Chairman of the Council on Medical Education; Dr. Philip C. Lynch, Chairman of the Council on Medical Service; Dr. V. P. Siegel, Chairman of the Council on Legislation, and Dr. Joseph O'Donnell, Trustee of the 11th District, where a preceptorship program is now in operation. The Task Force will meet with the Chairman of the Finance Committee to discuss budget.

BLUE SHIELD OFFERS NEW PROGRAM

Blue Cross-Blue Shield has informed the Board of a new program for individuals over 65 years of age not eligible for Medicare or unwilling to accept Part A or subscribe to Part B. Another plan will be offered to people over 65 who do have Part A and Part B under Medicare but who want supplementary benefits, including health care coverage outside the United States.

(Continued on page 355)



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Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.

Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.

Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the

possible risks, Tofrānil should not be used during the first trimester of pregnancy.

Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.

Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.

Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.

In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.

The drug is not recommended at the present time in patients under 12 years of age.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychoses in schizophrenics and agitation (ind-

Mycoplasma Pneumoniae Pneumonia

BY MAURICE A. MUFSON, M.D./CHICAGO

During the past decade, *Mycoplasma pneumoniae*, initially called the Eaton Agent, was identified as the causative organism of cold agglutinin-positive primary atypical pneumonia.^{1, 2, 5, 6, 14, 17, 27, 28} For many years, the etiologic agent of this disease was thought to be a virus, but in 1962 Chanock, Hayflick and Barile demonstrated that the Eaton Agent could be grown on agar and possessed the properties of a mycoplasma.³ Subsequently, the Eaton Agent was renamed *Mycoplasma pneumoniae* to connote its etiologic relationship to pneumonia.⁵ *Mycoplasma pneumoniae* represents the first demonstrated mycoplasma species pathogenic for man. Recognition of *Mycoplasma pneumoniae* pneumonia is important because this disease can be effectively treated with tetracycline or one of the tetracycline analogues and possibly erythromycin.^{4, 5, 26}

Historical Background

In 1944, Eaton, Meiklejohn and Van Herick reported the first studies with the agent of atypical pneumonia—the Eaton Agent or *Mycoplasma pneumoniae*.^{12, 13, 14}

These investigators recovered it as a filtrable agent, in embryonated eggs, from the sputum of patients with primary atypical pneumonia. The harvests from infected eggs produced pneumonia in cotton rats or hamsters following intranasal instillation. Serum obtained from patients with atypical pneumonia during convalescence neutralized the organism.

Because of technical difficulties, the early studies with the Eaton Agent failed to provide conclusive evidence of its pathogenicity. Employing fluorescent antibody techniques, Liu in 1957 demonstrated growth of the organism in chick embryo bronchial epithelium, and provided a specific, although laborious, method for quantitating antibody to the Eaton Agent.^{27, 28} In 1961 Marmion and Goodburn, based on their findings of the *in vitro* sensitivity of Eaton Agent to organic gold salts, suggested that the organism might be a mycoplasma rather than a virus.²⁹ One year later, Chanock and associates proved conclusively that Eaton Agent belonged to the genus mycoplasma.³ These investigators successively propagated the Eaton Agent on cell free agar medium, and demonstrated typical

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colonial forms which stained specifically with fluorescein-tagged Eaton antibody. The development of fluorescent microscopy procedures to measure *Mycoplasma pneumoniae* antibody and the cultivation of the organism on artificial medium provided the methodologic advances for investigating its prevalence and pathogenicity for man. Concomitantly, less laborious procedures developed for measuring specific *Mycoplasma pneumoniae* antibody, including complement-fixation, growth-inhibition, indirect hemagglutination and disc neutralization, encouraged further systematic epidemiologic investigation of *Mycoplasma pneumoniae* infections.^{7,10,25,26,37,44,45,46} Between 1957 and the present, a number of epidemiologic and volunteer studies established the importance of *Mycoplasma pneumoniae* in atypical pneumonia and febrile respiratory disease.^{1, 2, 11, 16, 17, 19, 21, 26, 39} Finally, the development of specific diagnostic tests for *Mycoplasma pneumoniae* infection provided a rational basis for evaluating antimicrobial therapy.

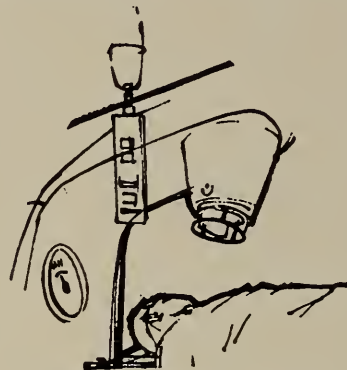
Properties Of Human Mycoplasmas

In the present taxonomy mycoplasmas are the smallest organisms capable of replicating in a cell free medium.^{15, 18, 20} Their approximate size ranges from 150 to 240 millimicrons. Mycoplasmas lack a rigid cell wall, but possess a triple-layered lipoprotein limiting membrane, and are highly pleomorphic. Most mycoplasmas require sterol, usually as cholesterol, which is incorporated into the limiting membrane. Acrylamide gel electrophoresis of individual mycoplasma species fractionates several components of differing mobilities and concentrations; the electrophoretic patterns apparently are characteristic for each species.

On agar medium, mycoplasmas form typical colonies ranging between 10 and 600 microns in diameter. Because the central area of the colony grows on and beneath the agar surface, it appears darker than the non-embedded peripheral zone; thus, the designation as "fried egg" colonies. Members of the genus mycoplasma are inhibited by tetracyclines, erythromycin, certain other broad spectrum antibiotics, and organic gold salts, but these organisms are resistant to penicillin.^{20, 23, 38} One group of mycoplasmas, the "T" strain mycoplasmas, an

antigenically heterogeneous group recovered from the human urogenital tract, are also inhibited by thallium acetate, and metabolize urea with the production of ammonia.³⁵ Other human mycoplasmas do not possess these properties. The metabolism of urea by "T" strains forms the basis of a color test for measuring the inhibition of these organisms by antibody.³⁵

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Mycoplasmas do not grow as bacterial forms.²⁰ Nucleic acid homology experiments indicate that *Mycoplasma pneumoniae* and the Streptococcus MG organism are distinct and unrelated.³⁰

Mycoplasma pneumoniae ferments glucose, maltose, xylose, mannose and starch, and other carbohydrates.²⁰ It is the only mycoplasma species which produces rapid complete (beta) lysis of guinea pig, human and horse erythrocytes.⁴⁰ The soluble hemolysin of *Mycoplasma pneumoniae* is a peroxide.^{40, 41} Other human oral mycoplasmas fail to ferment carbohydrates and produce incomplete (alpha) or no hemolysis. Although presumptive recognition of *Mycoplasma pneumoniae* strains can be accomplished on the basis of these two properties, confirmation of antigenic identity requires specific serologic tests.⁴⁰ To date, no antigenic differences have been detected among the *Mycoplasma pneumoniae* isolates tested.^{43,47,48,49} Unlike other mycoplasma species, methylene blue fails to inhibit the growth of *Mycoplasma pneumoniae*. Based on this finding, a media incorporating methylene blue has been formulated for the selective isolation of *Mycoplasma pneumoniae*.³⁸ *Mycoplasma pneumoniae* infection has

been experimentally transmitted to the cotton rat and Syrian hamster.^{9, 12}

Respiratory Tract Mycoplasmas

Mycoplasma species recovered from the human respiratory tract include: *Mycoplasma pneumoniae*, *Mycoplasma hominis* type 1, *Mycoplasma salivarium*, *Mycoplasma orale* type 1 (syn. *Mycoplasma pharyngis*) and type 2.^{5, 18, 20} *Mycoplasma pneumoniae*, the only proven human pathogen, has been recovered from the upper respiratory tract of ill and healthy individuals, and from the lung of ill individuals. *Mycoplasma hominis* type 1, which may be a human pathogen, has been recovered from the oropharynx and pleural fluid of ill and well individuals, and also from other sites, including the urogenital tract, blood and fallopian tubes.^{5, 20, 34} Three non-pathogenic species, *Mycoplasma salivarium*, and *Mycoplasma orale* types 1 and 2 have been isolated only from the oropharynx.

Mycoplasma Pneumoniae Pneumonia

Mycoplasma pneumoniae infection occurs world wide.^{5, 16, 21, 39} The spectrum of respiratory tract disease associated with *Mycoplasma pneumoniae* infection includes pneumonia, febrile respiratory disease, afebrile respiratory disease and bul-
lous myringitis.^{2, 19, 21, 22, 32, 39}

Depending upon the population, *Mycoplasma pneumoniae* accounts for from 5 to 40 per cent of pneumonic illnesses.⁵ Specific *Mycoplasma pneumoniae* pneumonia rates vary from about 1 per 1000 pneumonias annually among civilians to as much as 18 per 1000 pneumonias annually among certain military recruit populations.^{2, 19} Among hospitalized adults with pneumonia, *Mycoplasma pneumoniae* accounts for only about 5 per cent of these illnesses. Clinically, inapparent infection occurs commonly, and the risk of recognizable pneumonia during infection is approximately one in thirty infections or less.²

Although *Mycoplasma pneumoniae* infection occurs in all age groups, the majority of infections occur during childhood and continue into the second and third decades.¹⁹ The school aged child often carries *Mycoplasma pneumoniae* and represents an important focus for spread of the organism in the community. Secondary family infections occur commonly.

Close or prolonged contact may be re-

quired to cause transmission of infection.^{2, 5, 18} *Mycoplasma pneumoniae* infections spread slowly from person to person; the incubation period varies from 10 to 12 days. *Mycoplasma pneumoniae* infections occur throughout the year, without any apparent predominant seasonal pattern.¹⁹

Clinical Characteristics

Symptoms of *Mycoplasma pneumoniae* pneumonia become manifest several days before the development of roentgenographic evidence of pneumonia.^{19, 21, 33} Common complaints include cough, the most frequent symptom, headache, malaise, chills, and less often, nasal symptoms, sore throat, muscle aches, and chest pain. Hemoptysis, a rare occurrence, usually results from the trauma of coughing.

Fever occurs in almost all patients with recognized infections. Rales develop in a majority of patients, but may be absent at the beginning of illness. Cervical adenopathy, pharyngitis, and otitis occur in one-third or less of individuals with *Mycoplasma pneumoniae* pneumonia.

There is no specific radiographic pattern in *Mycoplasma pneumoniae* pneumonia. Most often unilateral, the pneumonic infiltrate involves one or more segments of the lower lobes; in relatively few patients, the middle and upper lobes are sites of involvement. The infiltrative process appears fluffy or patchy, usually bronchiolar or peribronchiolar, rarely lobar, and delineates the course of the radiating vascular markings.

Etiologic differentiation of *Mycoplasma pneumoniae* pneumonia cannot be established on the basis of clinical or radiographic findings. A specific diagnosis can be established by the isolation of the organism from the oropharynx, or by the detection of a four-fold or greater rise in antibody, or both.^{5, 16, 18} Antibody to *Mycoplasma pneumoniae* can be conveniently measured by complement fixation procedures.⁴⁴ This antibody determination can be included in complement fixation tests if routinely performed in hospital virus diagnostic laboratories; *Mycoplasma pneumoniae* antigen and specific hyperimmune antiserum can be purchased from commercial suppliers. In the State of Illinois, *Mycoplasma pneumoniae* complement fixing

antibody tests are performed routinely by the Virus Laboratory, Illinois Department of Public Health, in Chicago. More specialized techniques such as growth-inhibition, indirect hemagglutination, or immunofluorescence are limited to research laboratories.^{11,44,45}

Only about one-half of adults with *Mycoplasma pneumoniae* pneumonia develop cold-agglutinins.^{2,4,33} Most cold-agglutinin-positive atypical pneumonia is associated with *Mycoplasma pneumoniae* infection. Cold agglutinins more often develop in the severely ill patient. In children, no association has been demonstrated between the development of cold agglutinins and *Mycoplasma pneumoniae* infection.⁴²

Treatment

The recent development of specific diagnostic tests for the detection of *Mycoplasma pneumoniae* infection provided a rational basis for evaluating the effectiveness of antibiotics that inhibit the organism *in vitro* and in animals. Previously, uncertainty surrounding the question of efficacy of antibiotic treatment of non-bacterial pneumonias stemmed in part from reported treatment studies which were not conducted in a controlled fashion, and in which etiologic diagnosis could not be established for all pneumonias.^{5, 18, 20} In the early 1960's, an extensive double blind treatment study of atypical pneumonia among military recruits conclusively established the effectiveness of the tetracycline drugs in the treatment of *Mycoplasma pneumoniae* pneumonia.²⁶ Subsequent studies confirmed these findings and suggested that other broad spectrum antibiotics might also prove useful in the treatment of this disease.^{6,18, 23,38}

Current recommended treatment of *Mycoplasma pneumoniae* pneumonia includes: bed rest, adequate diet, liquids; salicylates and tepid sponge baths for high fever; anti-tussive medication in the absence of respiratory distress; oxygen or intermittent positive pressure breathing and bronchodilator drugs for respiratory distress; and, tetracycline 2 grams daily in divided doses for about 10 days or one of the tetracycline analogues — oxytetracycline, chlortetracycline, or demethylchlortetracycline—in a comparable dose. Erythromycin may also be effective in the treatment of *Mycoplasma pneumoniae* pneumonia.

Clinical relapse sometimes occurs and will respond to treatment with the same drugs. Asymptomatic relapses with positive cultures may be quite common.¹⁹ Although clinical improvement ensues soon after the start of treatment, eradication of the organism from the oropharynx is more difficult.^{19,38} Infected individuals can shed *Mycoplasma pneumoniae* for several months after becoming well; also the organism may reappear in the cultures of the treated individuals. During this period infected persons can communicate *Mycoplasma pneumoniae* to susceptible contacts. The mechanism by which *Mycoplasma pneumoniae* is eliminated from the respiratory tract remains unexplained.

Immunoprophylaxis

In high risk populations, the prevalence of *Mycoplasma pneumoniae* infections might be controlled by immunoprophylactic measures. Presently under preliminary investigation are two types of vaccines—inactivated vaccines and a live attenuated vaccine.^{8,24,31} Intramuscularly administered inactivated vaccines induce specific antibody. However, only limited field tests with these vaccines have been conducted. Administration of a vaccine containing live attenuated *Mycoplasma pneumoniae* by the nasopharyngeal route to a small number of volunteers also induced specific antibody to this organism without producing severe respiratory tract disease. When available, a *Mycoplasma pneumoniae* vaccine might have wide application among young adult populations and military groups.

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INTRAUTERINE TRANSFUSION IN Rh-ISOIMMUNIZATION

The difficulties of the technique of intrauterine transfusion and the accidents that can occur have been covered in this report, but some points require special emphasis. We believe that the amount of blood injected, particularly into a small foetus, is important. Theoretically, exchange transfusion in utero (Adamsons, 1966) should be safer, but the greater dangers involved must restrict its use, and its contribution to the problem of intrauterine death can only be minimal. Liley (1964) originally regarded the presence of ascites as a contraindication to intrauterine transfusion, but 12 of our survivors had ascites removed on at least one occasion and Bowman (1966) has also reported survival in similar circumstances. It is desirable to avoid injecting large numbers of lymphocytes at intrauterine transfusion, for it appears that immunologically competent lymphocytes may occasionally colonize the reticuloendothelial system and produce complications. (Cohen et al., 1965; Kadowaki, et al., 1965; Githens, 1966; Naiman et al., 1966). D.V.I. Fairweather, et al., *British Medical Journal* (Oct. 28) 1967.

Tracer System Developed for Air Pollution Control

Scientists at the Public Health Service's National Center for Air Pollution Control have developed a gaseous tracer system that is so sensitive that the gas used can be detected miles from the source in concentrations of one part per 100 trillion parts of air. The gas, sulfur hexafluoride, which is non-toxic, can be released in a known concentration and measured downwind to determine how much it has been diluted by the atmosphere. Successful experiments have been conducted over a range of up

to 70 miles from the source.

By using this tracer system, scientists expect to expand present knowledge of the dispersion and dilution forces of the atmosphere on gaseous pollution transported from one city to another.

One use to which the new technique can be put is to measure the dispersal effectiveness of tall smoke stacks. Air pollution control authorities may also be able to use the method to show transport of pollution across jurisdictional lines.

Control of Bacteriuria in Geriatric Populations

By MORTEN B. ANDELMAN, M.D./LINCOLNWOOD

Therapeutic failure in chronic urinary tract infections seems to be the rule. Until this can be changed, thinking in terms of complete cure should give way to the realistic consideration of disease control. Even though the relationship between bacteriuria and pyelonephritis is vigorously debated,¹ clearing the urine of bacteria seems a reasonable goal. If this goal is to be achieved, success will depend on prolonged and adequate therapy.

The drug of choice must, of necessity, be effective and safe when given for long periods. It should not allow patient intolerance to develop nor interfere with the use of other chemotherapeutic agents. Very few antibacterial drugs for urinary tract infections presently available meet these criteria, particularly the requirement of long-term safety.

Sulfonamides are probably used most frequently for long-term therapy of urinary tract infections. However, with these drugs there is the risk of the development of bacterial resistance and an ever-present danger of serious toxic reactions.^{2, 3} The threat of disorders of the hemopoietic system in particular, makes frequent blood analysis necessary. Similarly, because of the complications incident to treatment with

tetracyclines and penicillins (both natural and synthetic), these antibiotics in therapeutic levels are contraindicated for prolonged use.⁴ Other drugs such as nitrofurantoin, although less likely to create resistant organisms, have been known to produce side effects such as megaloblastic anemia, peripheral neuropathy,^{6, 7} and anaphylactoid^{8, 9} and allergic reactions.^{10, 11} Even with recently introduced antibacterial agents like nalidixic acid, resistance develops^{12, 13} and untoward side effects have been observed.^{14, 15} The widely used methenamine products have the disadvantage of needing supplemental urinary acidification in order to be effective.

Our study was designed to evaluate the effectiveness and safety of methenamine hippurate*¹² in controlling bacteriuria in geriatric patients with a history of chronic urinary tract infections. This salt of methenamine, unlike other methenamine products, does not require supplemental urinary acidification to be effective.

Material And Methods

Fifty-six patients were selected for this study on the basis of: 1) a history of repeated urinary tract infections, and, 2)

*Hiprex®, Riker Laboratories, Northridge, Calif.



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the presence of significant bacteriuria (a colony count of greater than 100,000 organisms per ml of urine). Each patient was screened for evidence of bacteriuria by means of the Stat-Test (Griess-Ilosvay nitrite reduction test). All Stat-positive patients were catheterized and sterile urine specimens obtained for urinalysis and culture.

Patients with positive urine cultures (a colony count of 100,000 organisms per ml) were placed on methenamine hippurate, one gram twice daily. Treatment was to be continuous for one year. Serial urinalyses and cultures were performed at two-week intervals until completion of the period of observation. When relapses occurred, i.e., if significant bacteriuria recurred during the course of therapy, urine cultures were again obtained at two-week intervals until a remission occurred. All urines for culture were obtained by catheterization throughout the period of observation. Blood analysis, including blood urea nitrogen (BUN) and serum glutamic oxalecetic transaminase (SGOT) were determined initially before therapy was instituted and repeated after one, three, six, and twelve months of treatment. Prior to initiating treatment, all drugs previously prescribed for urinary tract infection were discontinued.

Results

Results were evaluated on the basis of three criteria: 1) elimination of bacteriuria with no more than one recurrence of significant bacteriuria during the period of observation was considered a therapeutic success; 2) temporary or sporadic recurrence of bacteriuria after total elimination of infectious organisms was judged to be a par-

tial success; and 3) failure or no effect was considered when no clearance of bacteriuria occurred at any time during the course of therapy.

Of 56 patients entered in the study, 33 were females, ranging in age from 56 to 91 years (average age 76.7), and 23 were males, ranging in age from 39 to 92 years (average 73.8). All presented chronic urinary tract infections variously diagnosed as: pyelonephritis 39, urethrocystitis 14, and prostatitis 14. Included in these diagnostic groups were 14 patients with evidence of infections in more than one area of the urinary tract. Three patients were diagnosed as having non-specific chronic urinary tract infections.

Because of the age of our patients, existence of disease conditions unrelated to bacteriuria, and place of residence, deaths, transfers to hospitals for more extensive care, and transfers to their original residences were responsible for the large number of dropouts. In addition, we were dealing with elderly patients who were placed in nursing homes because they were disoriented and uncooperative. These patients, as experienced by us frequently, will arbitrarily refuse to take medication of any sort or will refuse to cooperate in obtaining urine specimens.

Table I illustrates the length of therapy patients received and reasons for dropout. Of the 56 patients in our study, 51 failed to reach the 12-month mark in treatment because of poor cooperation, discharges, hospitalization, or death, etc. For these reasons an attrition rate of 28.6 percent was experienced in those subjects with less than two months of therapy.

Table II illustrates results of treatment by consecutive months of therapy. Two

TABLE I
CASE DISTRIBUTION BY CONSECUTIVE MONTHS OF RX

Consecutive Months of RX	Total # Pts. Completing	Uncooperative	Deceased	Discharged From Home	Hospitalized	Side Effects	Study Terminated
Less than 1	10	2	4	2	1	1	0
1-2	7	3	2	1	1	0	0
3-5	10	5	3	1	1	0	0
6-8	9	2	1	3	1	1	1
9-11	15	4	1	0	0	0	10
12-14	5	0	0	0	0	0	5
TOTALS	56	16	11	7	4	2	16
%	100	28.6	19.6	12.5	7.1	3.6	28.6

TABLE II
RESPONSE TO THERAPY

Months of Therapy	Total Cases	Bacterial Clearing		Therapeutic Failures	
		No. of Cases	%	No. of Cases	%
Less than 3	15*	9	60.0	6	40.0
3-5	10	8	80.0	2	20.0
6-8	9	9	100.0	0	0.0
9-11	15	14	93.3	1	6.7
12-14	5	5	100.0	0	0.0
TOTALS	54	45	83.3%	9	16.7%

*Two patients had only a control reading and were not included in this table.

TABLE III
INCIDENCE OF NO RELAPSES WITH BACTERIAL CLEARING

Consecutive Months of Therapy	Total Cases With Clearing	Number with Therapeutic Success*	Percent with Therapeutic Success
Less than 3	9	9	100.0
3-5	8	4	50.0
6-8	9	5	55.6
9-11	14	7	50.0
12-14	5	0	0
TOTALS	45	25	55.6%

*Or no more than one incident of bacteriuria during treatment.

patients were not considered in this tabulation because they received less than one month of therapy. Of the 54 patients who were treated for a period of one to 13 months, only nine or 16.7 percent failed to show bacterial clearing and were considered therapeutic failures. Forty-five or 83.3 percent demonstrated a response to the drug. Of the nine failures, six patients or 66.7 percent received treatment for less than three months.

Table III illustrates the persistence of bacterial clearing in 25 (55.6 percent) of the 45 cases who responded to treatment and were considered a therapeutic success. Twenty patients (44.4 percent) had persistent or frequent relapses and were considered a partial therapeutic success.

In all cases the pathogenic bacteria identified at the time of the first control culture were *Escherichia coli*. Subsequently, alpha-hemolytic streptococci, staphylococci and pseudomonas were present on occasion in the urine of six patients.

No toxic reactions to the drug were noted in the results of any of the laboratory tests performed. In some patients renal func-

tion was already reduced at the start of the treatment, but did not deteriorate further as a result of treatment.

Discussion

Lindemeyer, et al¹⁶ succeeded in eliminating pathogenic organisms in 26 percent of a group of geriatric patients with a known chronic bacteriuria. They considered this result too poor to warrant the risk of exposing patients to the potential toxicity of antibiotics, and therefore recommended that all antimicrobials be withheld from asymptomatic elderly patients.

Long-term treatment with methenamine hippurate resulted in bacterial clearing of 83.3 percent of our patients. Our 16.7 percent therapeutic failures, in the majority of instances, occurred in patients who received less than three months of therapy. Of those with bacterial clearing, 55.6 percent remained free of pathogenic bacterial organisms during their course of therapy and were considered a therapeutic success, while 44.4 percent experienced relapses and were considered a partial therapeutic success. Continuous treatment of bacteriuria

with methenamine hippurate is justified and particularly in chronic pyelonephritis which can only be arrested, not cured.¹⁷ Maintaining sterility of the urine is an important factor in eliminating the effects of repeated bacterial insult to the kidney tissue by reinfection.

In our study there were many instances of controlled bacteriuria in spite of the urinary pH above 6.0. Despite the poor cooperation frequently obtained from patients in this age group, the remarkably low incidence of side effects and the twice daily schedule was especially agreeable to both patients and nursing staff.

Summary

Fifty-six geriatric patients taken from several nursing homes in the city of Chicago were treated with methenamine hippurate and bacterial clearing was obtained in 45 cases (83.3 percent). Of the 45 patients who responded to therapy, 20 or 44.4 percent had relapses during the course of therapy and 25 or 55.6 percent of the cases sustained bacterial clearing. Failure was obtained in only nine or 16.7 percent.

Adverse drug reactions were few and mild and no serious or toxic reactions occurred. Patient intolerance was not observed. Drug administration was simple to follow since the dosage required was only one gram twice daily.

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Describe Use of Computers in Monitoring Shock Patients

The use of computers to monitor the condition of patients in myocardial shock was described recently for physicians attending an American College of Cardiology meeting at The University of Chicago.

The speaker was Dr. Max H. Weil, associate professor of medicine and director of the Shock Research Unit at the University of California School of Medicine in Los Angeles.

The California medical facility has four special units to treat patients who have suffered a myocardial infarction and are in shock. Information from a number of monitoring systems is gathered and projected on a television screen in the room, providing immediate and continuing information for the medical team.

Dr. Weil said he believes there is rela-

tive overemphasis on blood pressure as a measurement of the patient's condition. He considers blood velocity and cardiac output to be more important immediate measurements.

He noted there are important changes in pulmonary function in myocardial shock, including a decrease of oxygen tension in the blood.

Immediate treatment outlined by the physician included securing proper ventilation, controlling bleeding or trauma, relieving congestion, and checking cardiac size and rhythm.

Because there often is a loss of fluid volume, Dr. Weil said, the UCLA team has found it effective to give large quantities of glucose and plasma.

The Diagnosis of Neck and Arm Pain by Examination

By RENE CAILLIET, M.D.,/LOS ANGELES, CAL.

Diagnosis and proper treatment of pain in the neck, or arm pain that originates in the neck, requires a basic knowledge of functional anatomy of the cervical spine. The examination must recognize the faulty function and the symptoms must be correlated with the faulty function. If the *specific pain* complained of by the patient can be reproduced by a position or a movement and the exact reaction of that position or movement is understood, the mechanism producing pain can be appreciated.

The cervical spine is an aggregate of superimposed *functional units* (Fig. 1). All units from the third cervical vertebra down to the first thoracic vertebra are basically similar. A functional unit consists of two adjacent vertebrae (Fig. 2) and is functionally divided into an anterior and a posterior segment.

The anterior segment is the weight bearing ing shock absorbing portion. The vertebral bodies are separated by intervertebral discs that are wider anteriorly than posteriorly which is responsible for the lordosis. These discs are compressible and permit flexion, extension, lateral flexion, and rotation of the neck.

The posterior portion of the functional unit consists of the pedicles, laminae, posterior processes, and the transverse processes.

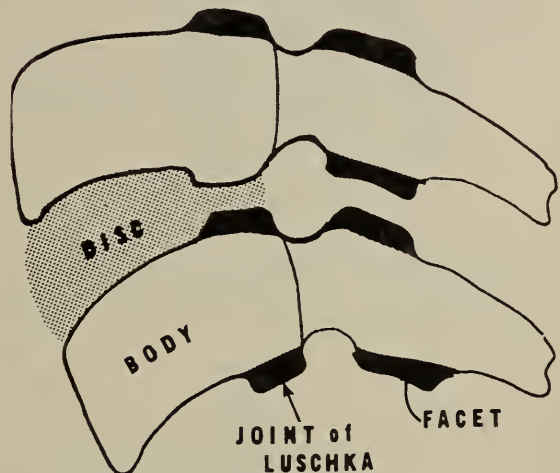


FIG. 1. Functional Unit.

The anterior weight bearing portion of two vertebral bodies separated by the intervertebral disc. The posterior guiding portion with its facets.

ses. In this portion are found the articulations: the zygoapophyseal joints. These joints are not principally weight bearing but act in a gliding manner to direct and limit the extent of neck motion.

The intervertebral foramen is bounded anteriorly by the posterior longitudinal ligament, posterior border of the disc annulus, and the uncovertebral joints of von Luschka. The superior and inferior margins of the foramen are formed by the pedicles, and the posterior margin by the

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This paper was presented May 23, 1967, during the 127th annual meeting of The Illinois State Medical Society.



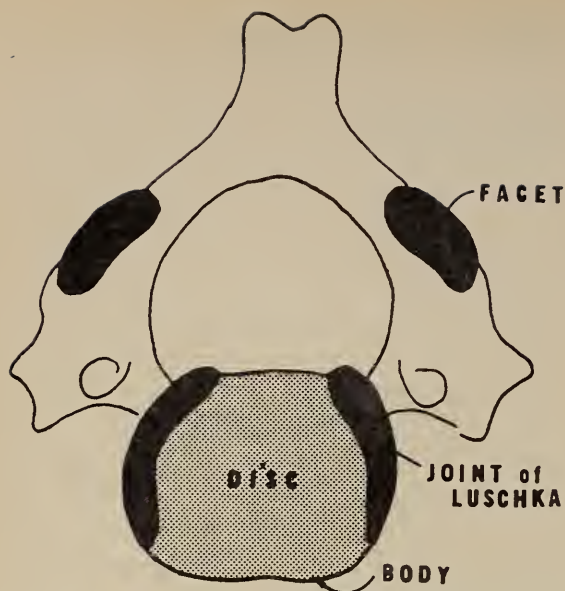


FIG. 2. Vertebral body:
The vertebral body showing the area of the uncovertebral joint of vonLuschka. The posterior segment with the two pedicles, the facets, the laminae, and the processes.

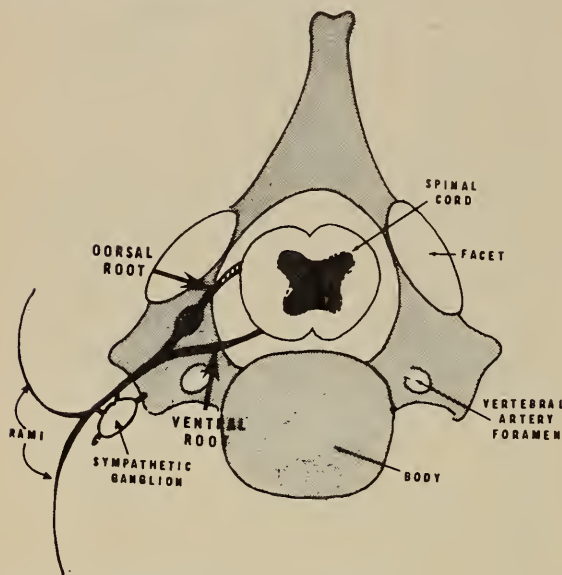


FIG. 3. Formation of a nerve root:
The posterior (sensory) and the anterior (motor) roots merge to form a common root that passes through the foramen. Outside the foramen a small unmyelinated nerve (recurrent meningeal nerve) reenters the foramen to supply sensory fibers to the posterior longitudinal ligament, the nerve, and the dura.

zygoapophyseal joints, also termed facets. Through this foramen passes the spinal nerve root (Fig. 3). As the nerve root together with its sleeve of dura and arachnoid passes through the intervertebral foramen it is accompanied by small blood vessels and sympathetic nerves. The nerve root and its accompanying tissues fill half of the foramen (Fig. 4) and thus is suscep-

tible to compression and inflammation if there is impingement into or narrowing of the foramen.

Movement of the cervical spine below the second cervical vertebra is that of gliding in which the second glides upon the third, the third upon the fourth, etc. As the spine flexes forward the posterior facets separate and the foramina open (Fig. 5). As the neck extends the foramina narrow. Rotation of the neck closes the foramen on the side *toward which the head turns* and opens them on the other side. External rotation and lateral flexion, as well as extension, are motion which may compress the nerve roots during their passage through the foramen (Fig. 6).

The spinal nerves are formed by numerous fila that merge into roots which become enclosed in a dural sleeve (Fig. 7). The nerve emerges from the interspace above its similarly numbered vertebra with the exception of C_8 which emerges above T_1 (Fig. 8). Each nerve has a specific motor and sensory function in the head, neck, and upper extremity (Fig. 9).

The anatomy and function of the first two vertebrae are different than the other functional units of the neck. There is no disc and there are no posterior facets between the occiput and the atlas (C_1) nor between the atlas and axis (C_1 and C_2) (Fig. 10). The nerves that emerge at these levels therefore do not pass through intervertebral foramina. They also do not innervate any sensory or motor component of the upper extremity. Their function is mostly sensory to the scalp and face. They are most often involved in headaches caused by cervical muscular tension from which the nerves are "entrapped" and irritated.

The movement of the occiput upon the atlas is one of slight flexion and extension in a "nodding" motion of approximately 30 degrees (Fig. 11). No rotation or lateral flexion occurs at this joint. Motion between the atlas and the axis (Fig. 12) is one of rotation: 45 degrees to either side for a total of 90 degrees head rotation. Slight flexion and extension occurs at this joint. If no motion occurs below C_2 the head is able to flex and extend 45 degrees and rotate 90 degrees. The composite of possible motion is illustrated in Fig. 13.

Pain felt in the neck and in the arm

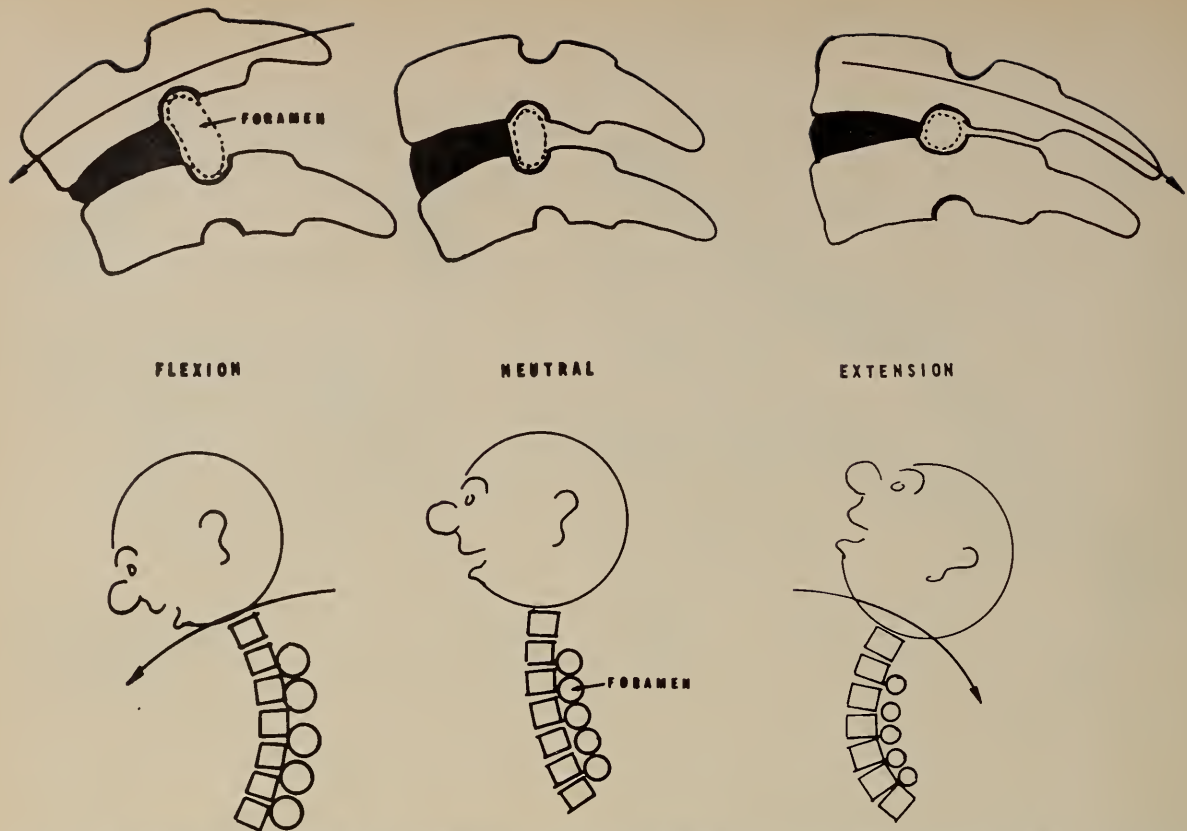


FIG. 5. Foraminal opening in relation to flexion-extension. In neck flexion the cervical vertebral glides forward and the foramen opens. In extension the posterior gliding closes the foramen.

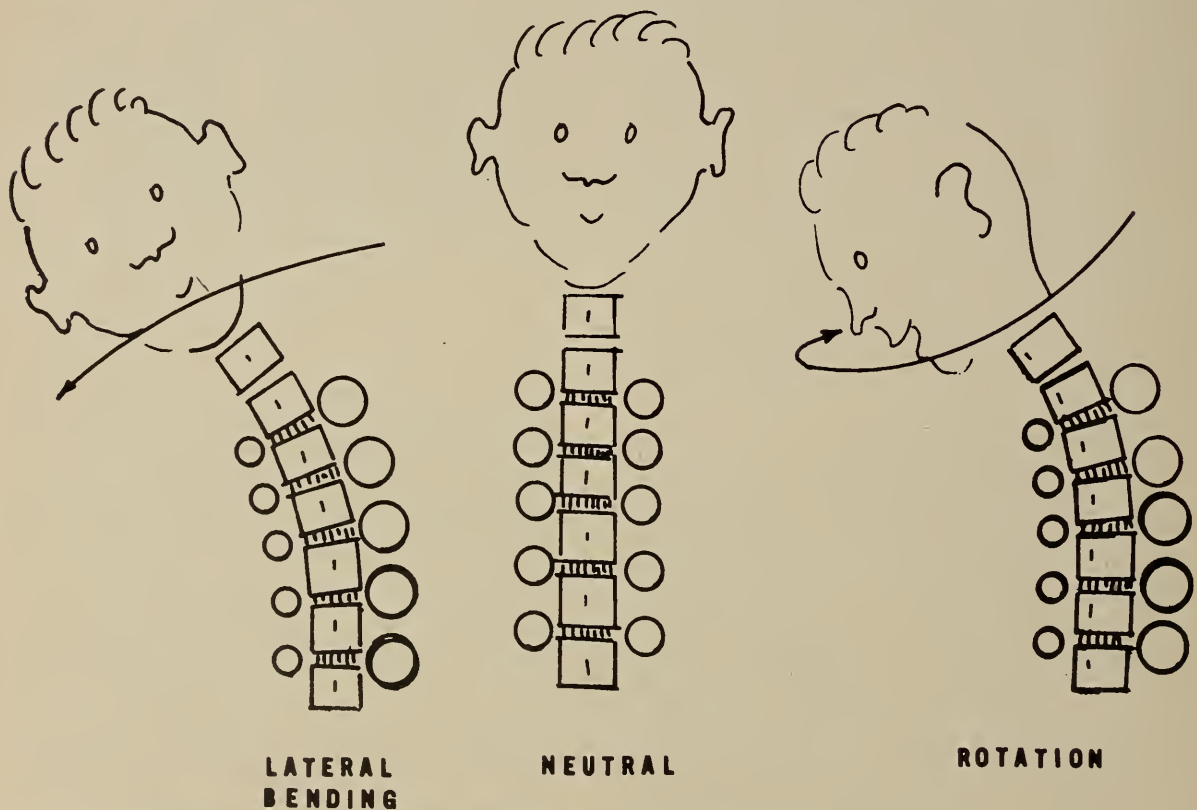


FIG. 6. Opening of foramen with lateral flexion and rotation. The foramen on the side *towards* which the neck flexes laterally or rotates *close*. The foramina opposite to the side to which the neck bends and rotates *open*.

The "tense" person from either emotional or postural-occupational causes will maintain his neck extensor muscles in a state of sustained isometric contraction. The muscles become painful and tender, the myofascial attachment of these muscles at the base of the occiput become tender, and the greater occipital nerve may become entrapped and thus cause pain referred in a hemicranial distribution. Occipital vertex headaches augment the cervical tension symptoms. Examination of these patients reveals the tell-tale signs of deep seated tensions and anxiety, restricted motion of the neck in all directions, and diffuse tenderness of all the neck muscles.

The post traumatic cervical sprain will present the same "guarding" of all neck motions. The neck muscle spasm may al-

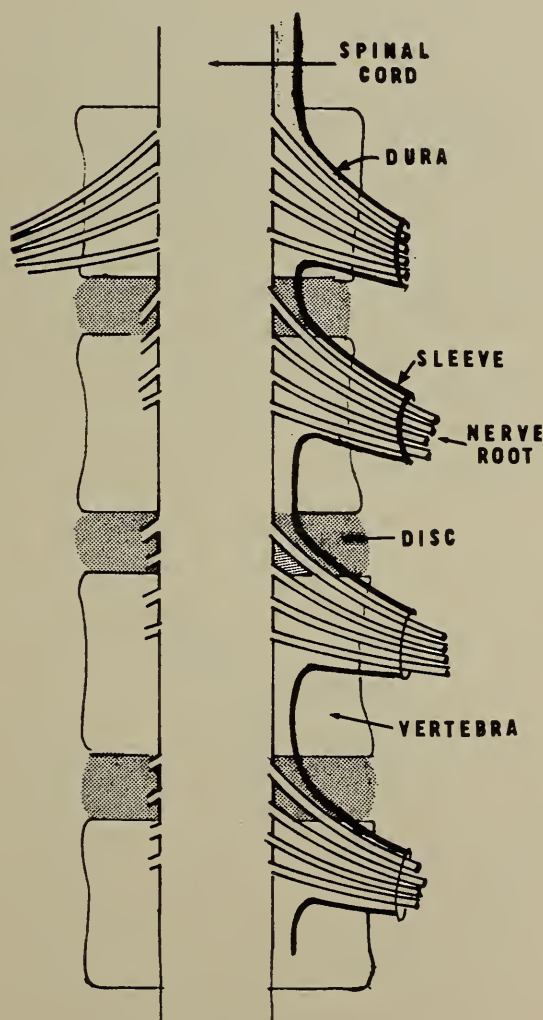


FIG. 7. Formation of a nerve root: Numerous fila of the cord emerge and join to form a root. As it emerges through the dura it makes a sleeve which accompanies it to the foramen.

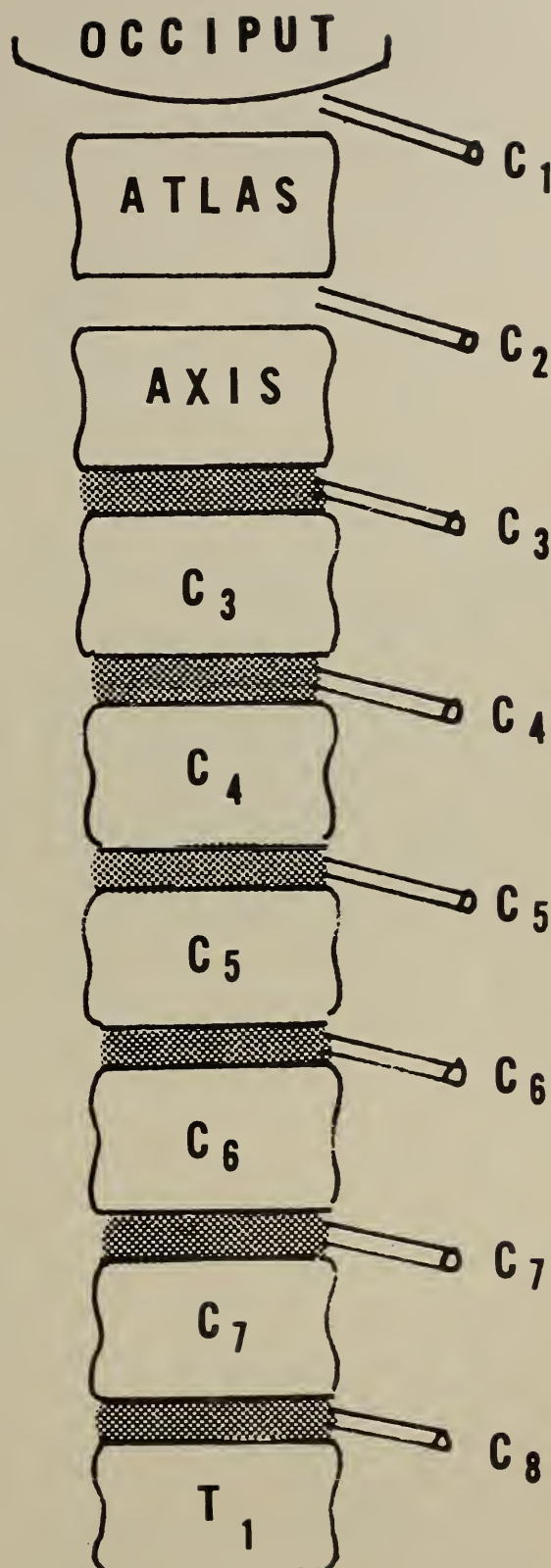
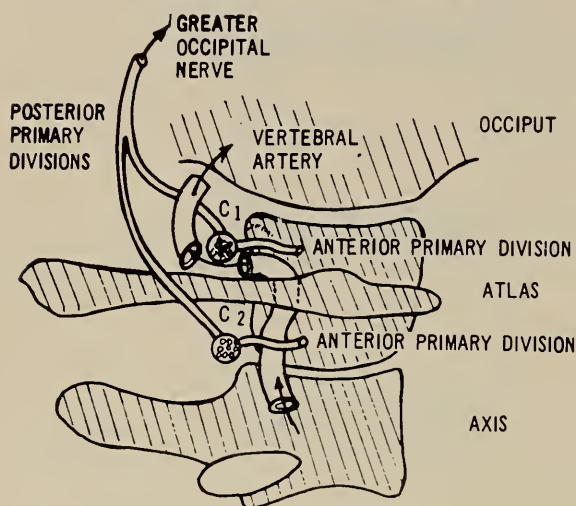


FIG. 8. Level of nerve root: Each nerve root (numbered) emerges above its similarly numbered vertebra except C8 which emerges above T1.

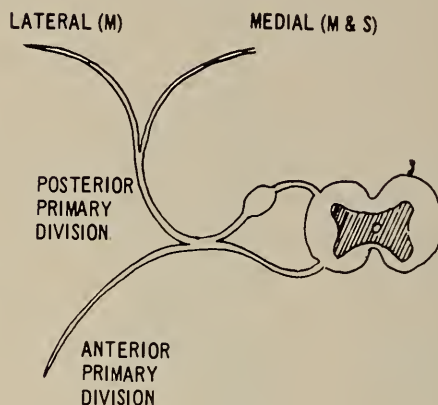
- C5—Shoulder abduction and external rotation
- C5—Elbow flexion
- C6—Shoulder adduction and internal rotation
- C6—Forearm supination
- C7—Elbow extension
- C7—Forearm pronation
- C8—Intrinsics of hand-fingers

Fig. 9

ter the cervical lordosis and present a "straightening of the curve" on x-ray studies. When the patient is seen soon after an injury that has caused severe hy-



A



B

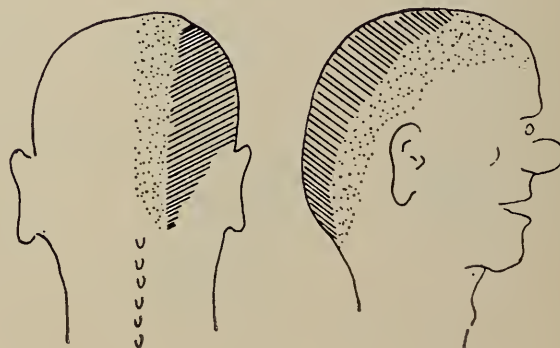


FIG. 10. Upper two vertebrae:
The atlas (C1) and the axis (C2) have no interposed discs and no posterior articulation similar to the remaining functional units. The nerves emerge through soft tissue rather than a foramen and supply sensation of the head and face with very little motor function.

perextension of the neck, a reflex weakness of the neck flexors may be elicited in which the patient is unable to lift his head from the bed or examining table unassisted. Within a few hours to a few days the neck becomes restricted in motion due to protective spasm. The flexor weakness may persist for many days.

Pain originating from the cervical spine may be referred into the interscapular area and into the arm, hand, and fingers. As the site of nerve encroachment is the intervertebral foramen specific movements of the neck should reproduce the symptoms. Neck extension and rotation of the neck towards the side of pain radiation should cause the nerve to be compressed because

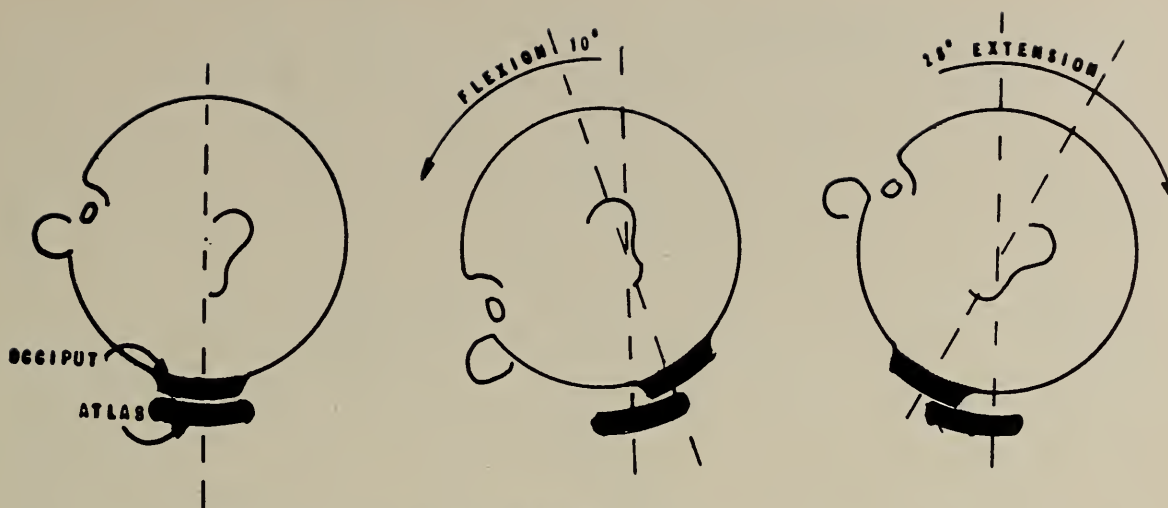


FIG. 11. Movement of the occiput upon the atlas:
Motion of the head upon the first cervical vertebra is merely flexion and extension through a range of approximately 35 degrees.

this motion causes foramen closure on that side (Figs. 5 & 6). If a protruded intervertebral disc is suspected as the cause of nerve root encroachment neck flexion may aggravate the symptoms by elongating the spinal canal and applying traction upon the inflamed congested nerve root.

The cutaneous area supplied by a single nerve root is known as a *dermatome*. The pain or paresthesia claimed by the patient is frequently referred to the specific dermatome area (Fig. 17). The group of muscles supplied by a single nerve root is known as a *myotome* (Fig. 9). The clinical examination of the upper extremity by checking the deep tendon reflexes, the muscle group strength, and areas of diminished sensa-

tion differentiate the lesion as a root lesion rather than a peripheral nerve lesion. The exact level of nerve root involvement in the cervical spine is also established.

The C_6 , C_7 and C_8 nerve roots are the most frequently involved insofar as the greatest degree of disc degeneration occurs between C_5 - C_6 and C_6 - C_7 vertebrae. Encroachment upon the sixth cervical root (emerging between C_5 and C_6 vertebrae) will cause paresthesia and hypalgesia of the thumb and index finger, weakness of the biceps muscle and biceps reflex, and pain noted in the interscapular region. The seventh nerve root will cause sensory impairment of the index and middle finger, depressed triceps reflex, and weakness of

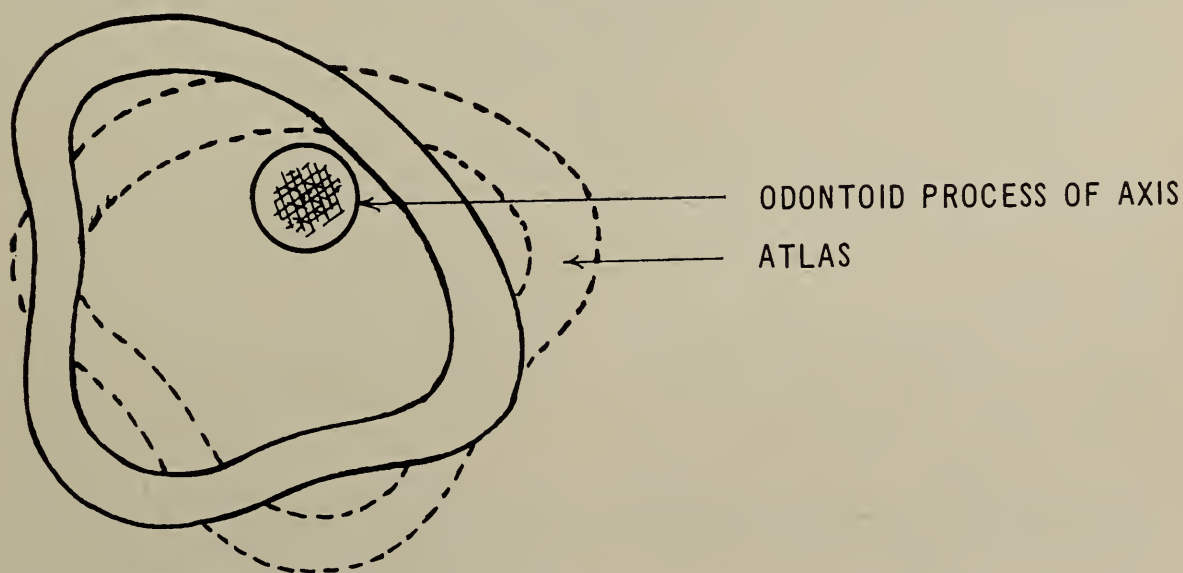


FIG. 12. Motion of the atlas upon the axis:
The atlas (C_1) moves in a rotatory manner about the axis (C_2) permitting rotation of 45 degrees to the left and 45 to the right: a total of 90 degrees.

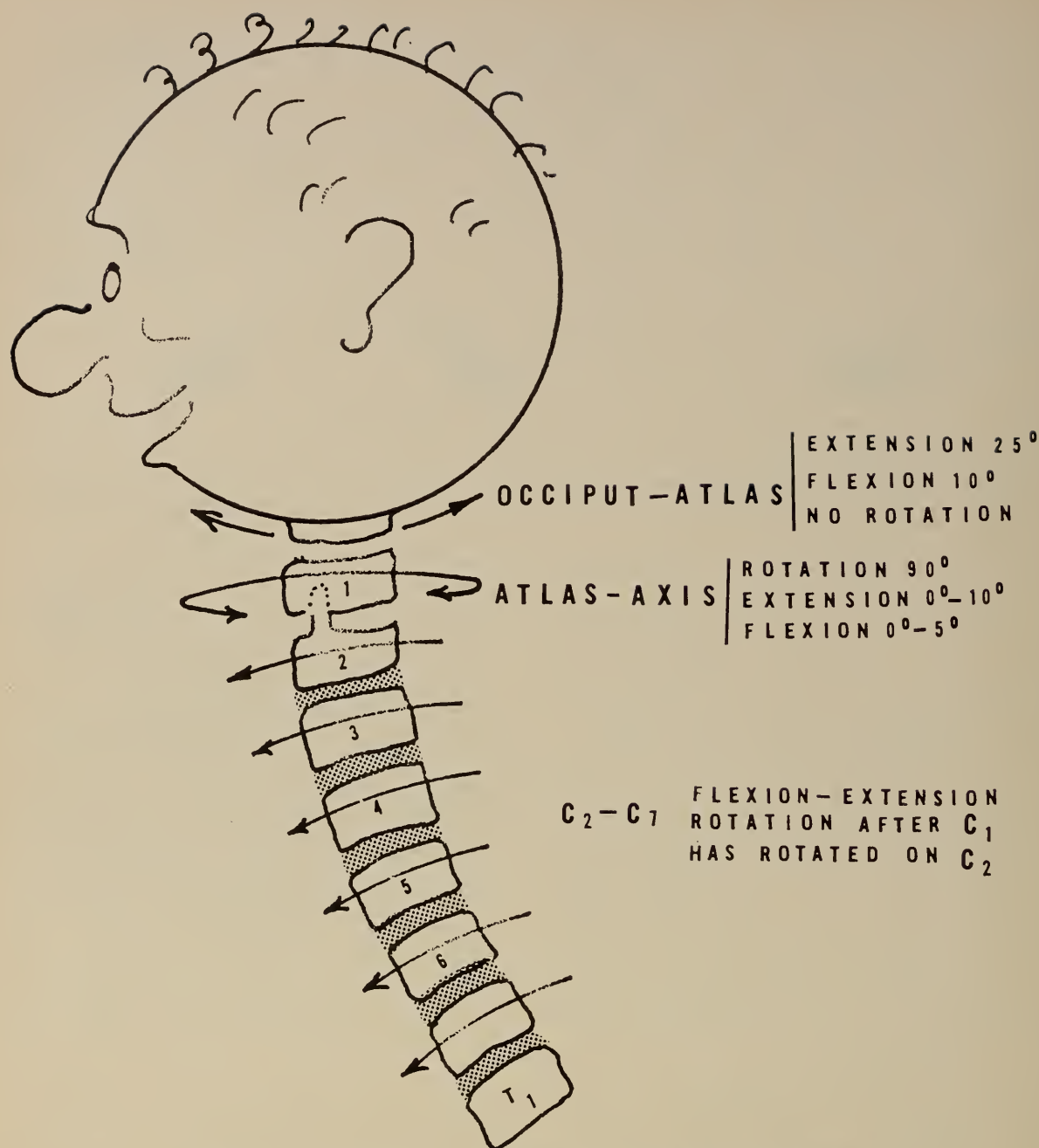


FIG. 13. Composite of all motions at various cervical levels

the triceps. The eighth nerve will result in sensory loss of the little finger and weakness of the intrinsic of the hand but no reflex changes.

Clinical examination in which the history and physical examination is based on concepts of functional anatomy will reveal the pathological mechanism as well as the site of pain production. X-rays, electromyography, myelography, and discography merely confirm the clinical impression.

Treatment that is based on functional anatomical concepts can be directed towards relieving or removing the offending mechanisms and permit natural resolu-

tion of the inflammatory reactions upon the nerve root. Immobilization of the neck to permit recovery of the strained ligaments, minimize protective muscle spasm, and allow the inflamed edematous nerve roots to recover must place the neck in a position of *slight flexion*: slight reversal of the lordotic posture. This position separates the posterior facets and opens the foramina. Posture training and evaluation of occupational postures must keep this concept in mind. Traction, to be effective, must also slightly flex the spine rather than attempt to distract the vertebrae.

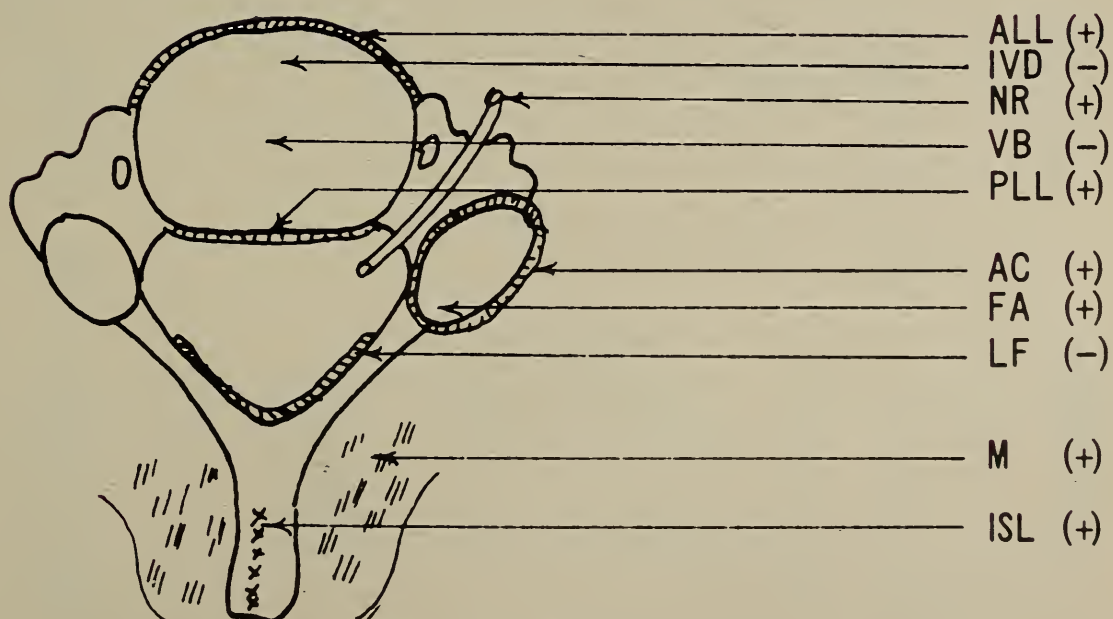
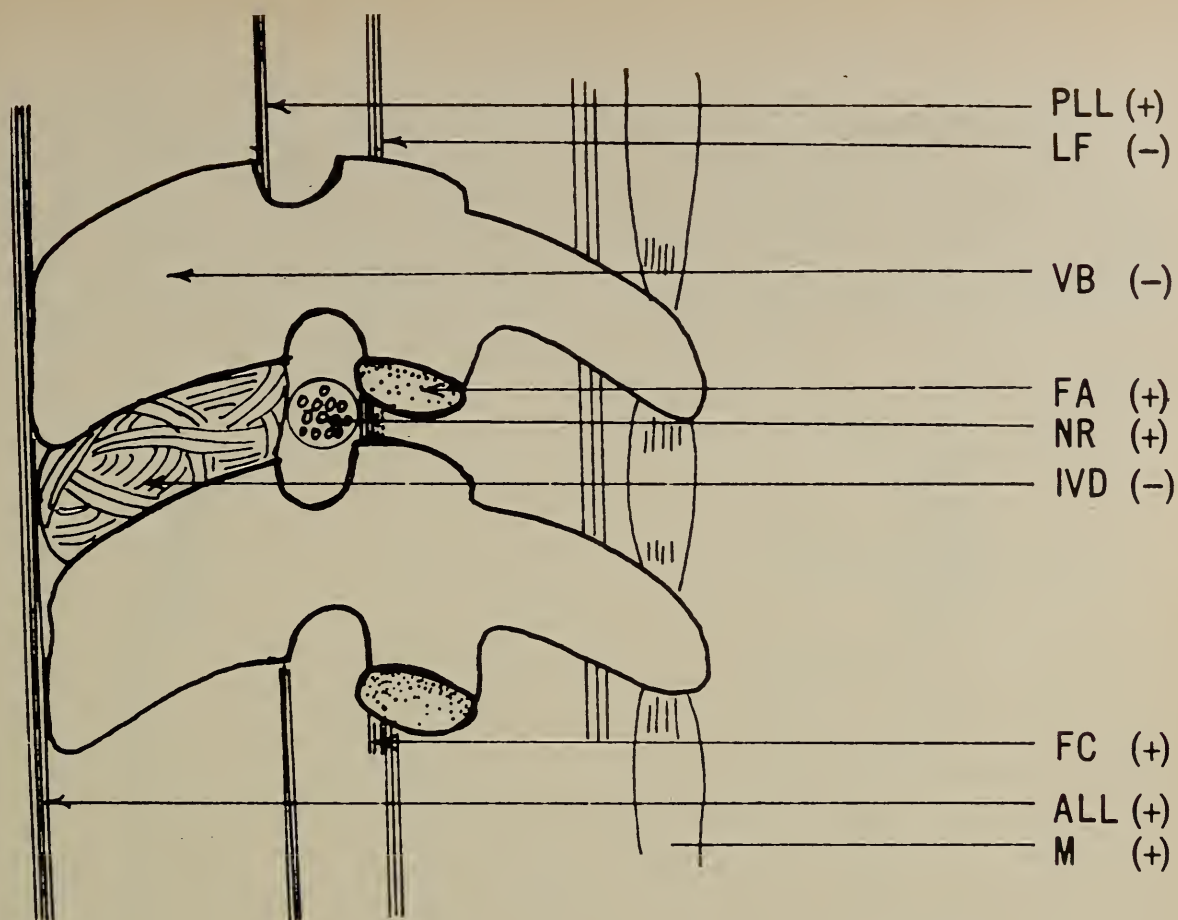


FIG. 14. Pain sensitive tissues within a functional unit. The most significant pain sensitive tissues are in the vicinity of the foramen; viz: the posterior longitudinal ligament PLL, the nerve root NR, and the facets FA. The dural sheaths are not shown in the drawing.

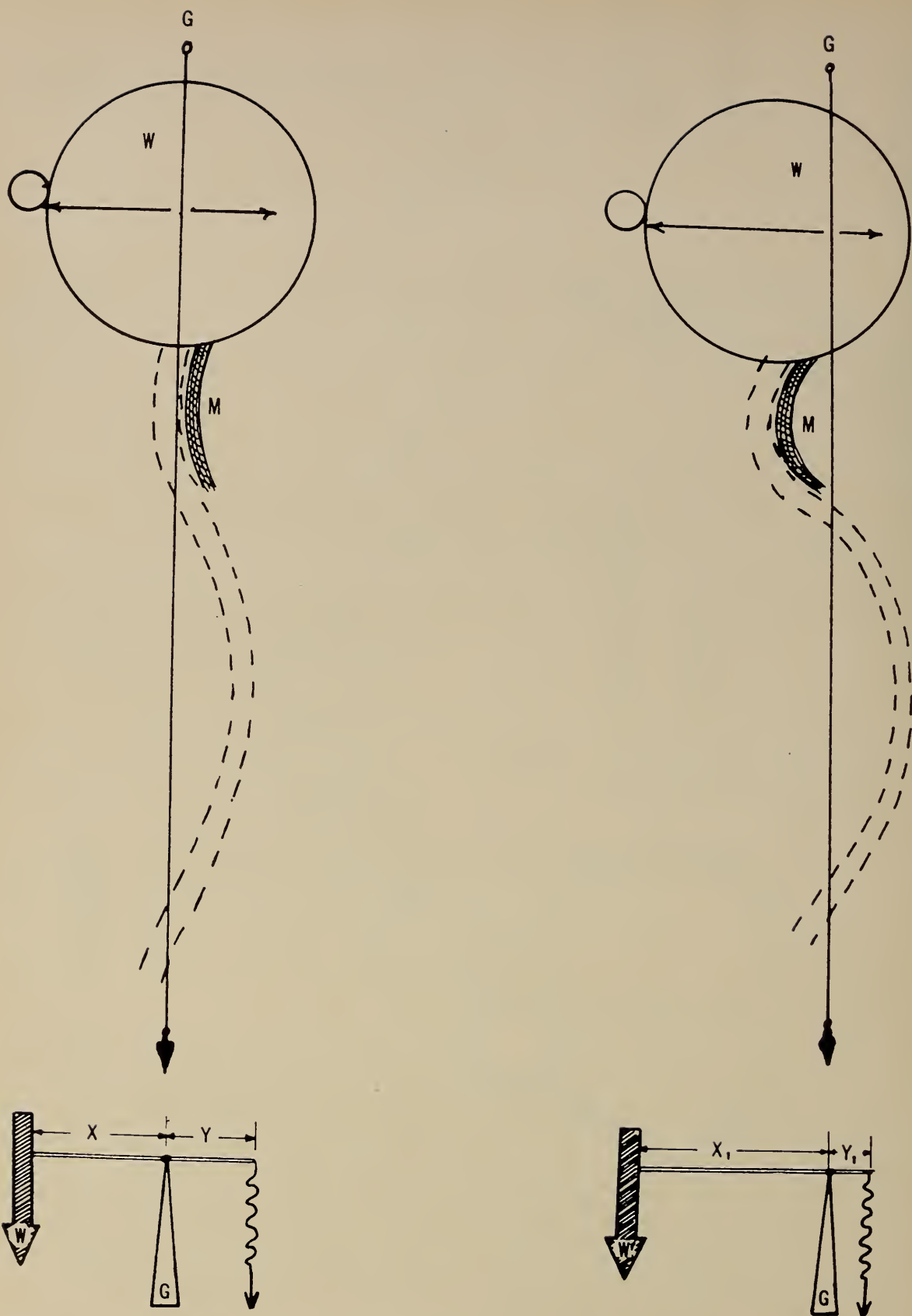


FIG. 15. Postural stress upon the cervical spine:
 The figure on the left shows proper posture in which the head is well balanced upon a minimal lordotic spine. A "forward head" posture creates a longer lever arm X_1 and thus increases the weight of the head requiring more tension of the posterior cervical muscles Y_1 .

Therapeutic exercises must be used judiciously. Active exercises or forceful assisted exercises during the acute phase of ligamentous irritation or nerve root edema may be detrimental. Upon subsidence of the acute stage exercises to strengthen "weak" muscles or elongate shortened "spastic" muscles must be gradually insti-

tuted. The necessary muscular tonus to insure proper posture must be established.

The degenerative changes within the cervical spine that existed but were asymptomatic before the stress of injury, emotions, or faulty posture will remain but the symptoms and potential nerve damage can be relieved.

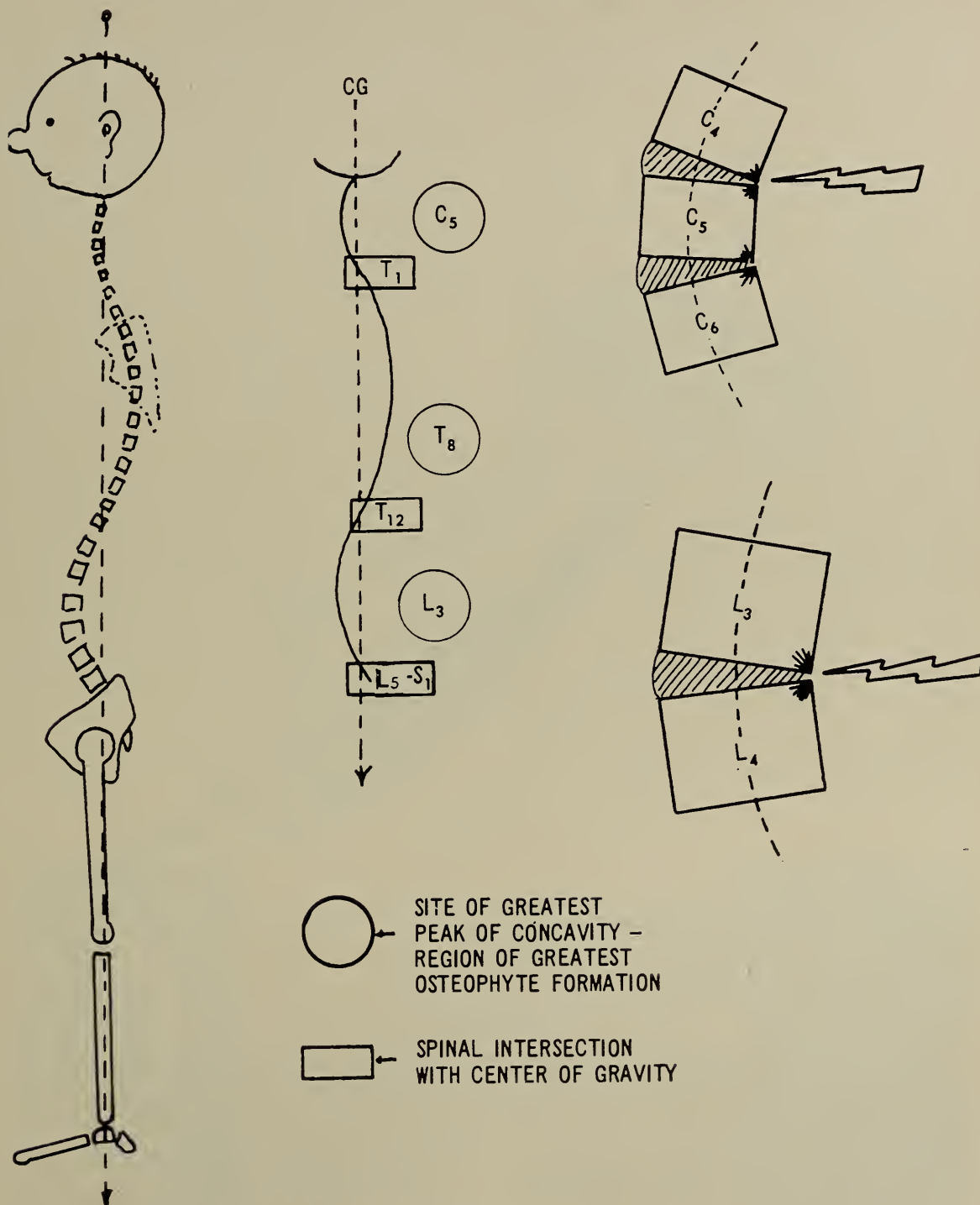
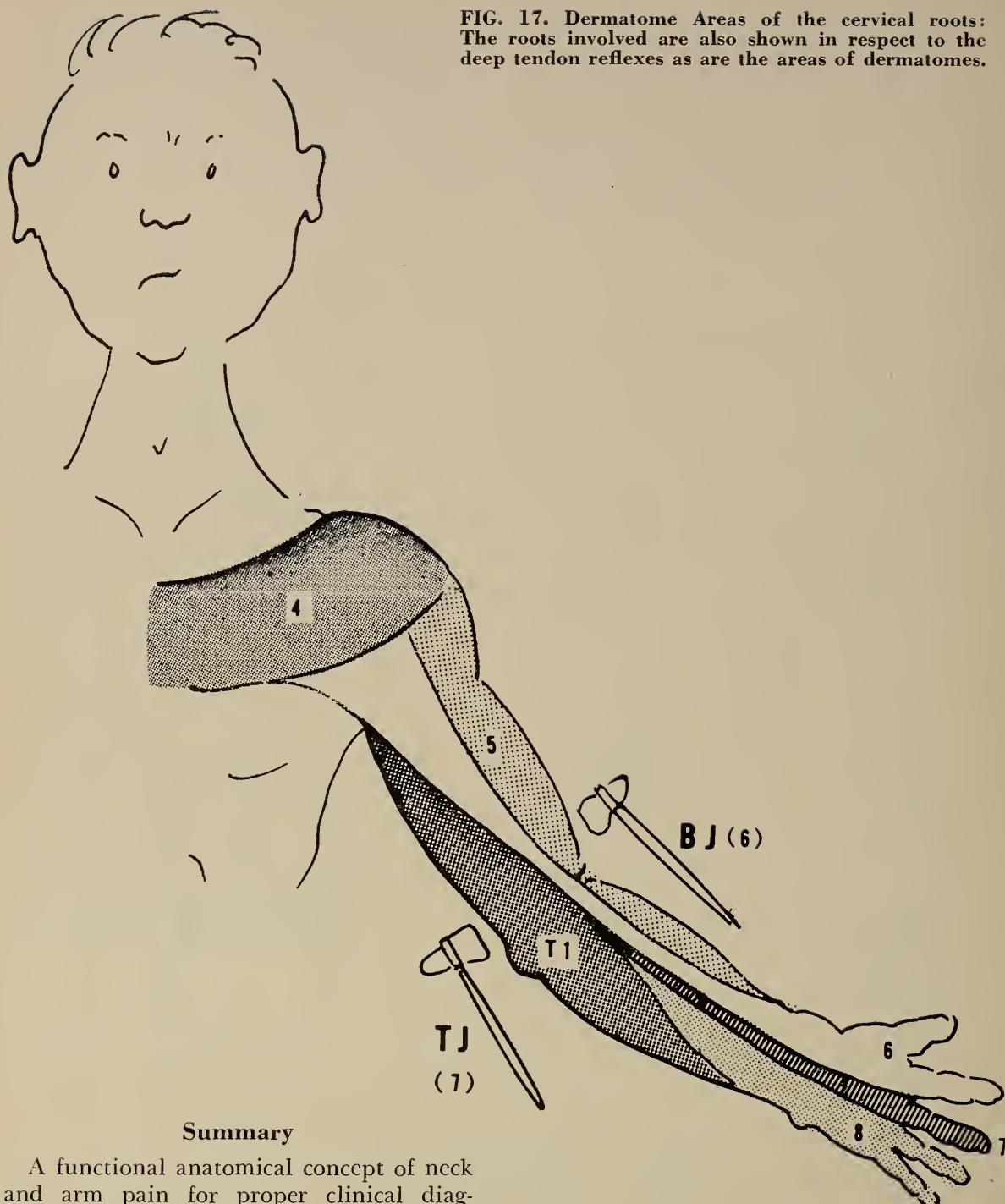


FIG. 16. Sites of greatest osteophyte formation: With an increase in lordosis there is closure of the posterior elements and thus more weight bearing there. Osteophytes form at the greatest angle of curvature: C5-C6. Increase in postural lordosis increases the formation of osteophytes.

FIG. 17. Dermatome Areas of the cervical roots:
The roots involved are also shown in respect to the deep tendon reflexes as are the areas of dermatomes.



Summary

A functional anatomical concept of neck and arm pain for proper clinical diagnosis has been discussed with a practical basis for treatment evolving.

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Clinical Experience With Methacycline In Children

By AARON GROSSMAN, M.D. AND K. RAMANATHAN, M.D./CHICAGO

Methacycline is one of the five clinically active tetracycline antibiotic agents. It has been demonstrated that methacycline (Rondomycin® Pfizer Laboratories) is more active, *in vitro*, against a number of bacteria than other tetracycline agents.¹ It has also been shown that methacycline is quite effective against many gram-positive as well as many gram-negative organisms.² It was the purpose of the present study to clinically evaluate the effect of methacycline syrup in 56 cases of infectious disease in children.

Materials And Methods

Subjects for the present study include 30 male and 26 female pediatric patients; ages ranged from 6 weeks to 12 years with an average age of approximately 3 years. Their weights varied from nine to 110 pounds. In each case infection was severe enough to require hospitalization. Tests done in the laboratory of the hospital included serum glutamic oxaloacetic transaminase and serum glutamic pyruvic transaminase measurements. Other measurements included blood urea nitrogen, blood counts, urinalyses, and bacteriologic cultures and sensitivity studies.

Medication in all cases consisted exclu-

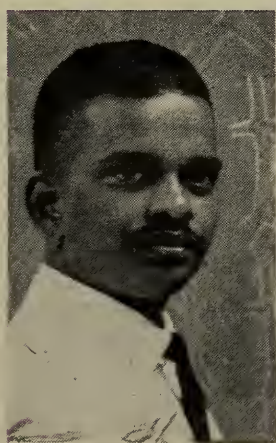
sively of methacycline, administered in a syrup, containing 15 mg. methacycline/ml. Equal doses totaling 6 mg./lb. of body weight were given either every 6 or 12 hours.

Results

Table I lists the diagnoses encountered and responses to methacycline therapy in all cases. By far the most common diagnoses were lobar pneumonia and pharyngitis, each of which occurred in 16 patients. Of the 56 children treated with methacycline, there were a total of 48 good, seven fair, and one poor response.

A good response to the treatment in most cases was determined by: relief of symptoms within a reasonable length of time; subsidence of temperature within a short time after initiation of methacycline treatment; and negative culture. (Table I)

Table 2 shows the microorganisms isolated in these patients, and appropriate responses to methacycline treatment. In only one instance was a poor response encountered; this was a patient with bronchopneumonia demonstrating a *Proteus mirabilis* infection. The most common organisms encountered in these infections included *Diplococcus pneumoniae* and *Staphylococcus*



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K. Ramanathan, M.D., received his degree in medicine from Madras Medical College, India. He is presently engaged in the practice of pediatrics. His internship was served at McNeal Memorial Hospital, Berwyn, Ill. while a residency in pediatrics was taken at Mt. Sinai Hospital, Chicago. Dr. Ramanathan is a Corresponding Fellow of the American Academy of Pediatrics.



Table 1
DIAGNOSIS AND RESPONSE TO
METHACYCLINE THERAPY

Diagnosis	Good	Fair	Poor
Lobar pneumonia	15	—	1
Bronchopneumonia	7	1	—
Pharyngitis	13	3	—
Sinusitis	5	—	—
Otitis media	—	2	—
Laryngotracheobronchitis	2	—	—
Pyelonephritis	1	—	—
Cystitis	1	—	—
Cervical lymphadenitis	1	—	—
Cervical abscess	1	—	—
Dermatitis	1	—	—
Stomatitis	1	—	—
Gastroenteritis	—	1	—
TOTAL	48	7	1

Table 2
BACTERIA CULTURED* AND RESPONSE
TO METHACYCLINE THERAPY

Organism	Good	Fair	Poor
Dip. Pneumoniae	15	3	—
Staph. Aureus (coag. +)	16	4	—
Hem. Strep.	6	1	—
Kleb. Pneumonia	4	—	—
H. Influenzae	5	—	—
Pseudomonas Aeruginosa	2	—	—
Porteus Vulgaris	1	—	—
Proteus Mirabilis	—	—	1

* Cultures of more than one bacteria were obtained from 12 patients.

aureus (coagulase positive). There were 15 good and 3 fair responses in the cases culturing *Diplococcus pneumoniae*, and 16 good and 4 fair responses in cases culturing *Staphylococcus aureus*. Cultures from 6 patients were either negative or produced a normal growth of organisms. More than one type of bacterium was obtained from 12 patients.

In 43 cases in the present study, temperatures had been elevated at the initiation of methacycline treatment. Twenty-five of those, or more than 50 percent, had returned to normal temperature ranges within 24 hours after the initiation of treatment. By the end of 48 hours, an

additional 12 patients' temperatures had returned to normal. It was possible to discontinue methacycline in 28 of the 56 patients within one week of treatment, and to discontinue the drug in 21 patients between the eighth and eleventh day. Only six patients required treatment longer than 11 days. There was no significant difference in the patients' response between the two dosage schedules.

No hepatic or renal or other abnormalities were encountered in laboratory tests throughout the present study. The syrup treatment was well tolerated and accepted. No untoward gastrointestinal symptoms resulted.

Summary

Fifty-six pediatric patients with moderate to severe infections were treated with methacycline in the syrup form. Treatment was successful in all but one case of lobar pneumonia. Methacycline appeared to be effective against some gram-negative as well as the more frequently occurring gram-positive organisms, including coagulase positive *Staphylococcus aureus*.

Methacycline was well tolerated in the syrup form in pediatric patients; and no gastric distress or diarrhea developed. Also there was no complicating involvement of either the liver or kidney by this treatment.

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4 State Hospitals Receive Accreditation

Four additional Illinois State Hospitals have been accredited by the Joint Commission on Accreditation of Hospitals.

Alton State Hospital, Anna State Hospital and Elgin State Hospital accreditation raised the total of state facilities receiving this distinction to 11. Accreditation

of Galesburg State Research Hospital, the fourth facility to be notified, originally attained in 1965, was renewed following a recent inspection by the commission.

Elgin State Hospital, with approximately 4,500 patients, is the largest facility in Illinois to be accredited by the commission.

Report of One Case And Review of the Literature

Ruptured Splenic Artery Aneurysm

By ISIDORO GUN, M.D. / CHICAGO

Aneurysms of the splenic artery are rare. Very few cases have been reported in the American literature. Schug and Rankin¹ in a collective review submitted for publication in Oct. 14, 1964, and published in May, 1965, were able to count 371 cases. Of these, 317 were collected by Cartier² through 1962 from the world literature. Since Oct. 14, 1964, we were able to collect from the literature seven additional cases adding a case of our own and bringing the total number of cases to 379.

Beausier³ in 1770 reported the first description of splenic artery aneurysm recounting a case which he had found in 1760 while preparing an anatomic demonstration. In 1869 Carson⁴ of Conshohocken, Pa., reported the first case of a ruptured splenic artery aneurysm in pregnancy. His patient died suddenly in the eighth month of her third pregnancy. Many observers found such lesions after death and only in 1903 Winkler⁵ identified one while operating upon a nurse who had suffered abdominal pains for eight years. This was also the first report of a prolonged survival as she recovered and lived for 25 years. In 1940 McLeod and Maurice⁶ reported the first survivor after rupture of the artery. There have been 54 well documented cases of ruptured aneurysm of the splenic artery in pregnancy with only 10 maternal survivors, the maternal mortality being 80 percent. When rupture occurred in the third trimester of pregnancy, the fetal mortality was 92.5 percent.

Despite the large number of such cases found at operation or autopsy, only 14 had been correctly diagnosed preoperatively and confirmed by surgery prior to 1952.

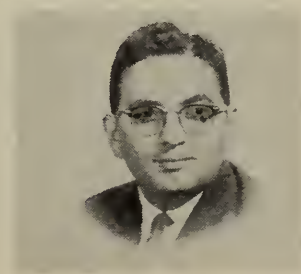
Case Report: Patient R. McD., Admission No. 370386 to Mount Sinai Hospital, Chicago. Thirty-two year old negro female. She was seen initially in the emergency room where she complained of abdominal pains of four days duration with nausea, vomiting and diarrhea several times a day. She was treated two days previously by an antiemetic injection at another institution. Pain was mostly located in the lower abdomen the day of admission. She felt dizzy and weak.

Past history revealed that the patient had these pains in the past; however, not as severe as the present attack. Blood pressure was 120/80 and pulse 104 on admission.

Physical examination revealed a thyroid somewhat enlarged, a grade II systolic murmur over the aortic area. The abdomen was soft, globulous, no masses were felt, and it was silent, diffusely tender, with diffuse rebound which was more pronounced at the lower abdomen. Rectovaginal examination revealed a bloody discharge (the patient was menstruating). There was exquisite tenderness at the mobilization of the cervix.

The patient was admitted to the hospital with the diagnosis of pelvic inflammatory disease, anemia and suspected ectopic pregnancy. On admission, hemoglobin and hematocrit were 7.2 grams and 21 percent respectively, the white blood count 9,400, and the urinalysis revealed protein trace,

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granular and hyaline casts. *Trichomonas* was seen. BUN of 56 and creatinine 3.7 were recorded. A pregnancy test (frog) was negative.

The patient was taken to surgery where colpocentesis revealed free blood, non-clotting, from posterior cul-de-sac. Abdominal exploration followed through a low midline incision, revealing absence of an ectopic pregnancy. However, a large amount of free blood was present in the peritoneal cavity. The incision was extended upwards, and a large retroperitoneal hematoma was found in the left upper quadrant. The spleen was overriding in the hematoma, obscuring the view. This organ was felt and found to be very soft. Splenectomy was carried out in order to have a clear field, and the splenic artery was found to be bleeding freely proximal to a ruptured splenic aneurysm. Hemostasis was done and the abdomen closed. A drain was placed in the left upper quadrant and brought through a separate stab wound in the side. The patient's recovery was uneventful. Postoperatively, her blood pressure rose to 210/130.

Pathology Report: Specimen I consisted of an irregular piece of fibro-fatty tissue with blood clots measuring 5.5 x 2.5 x 3 cm. In this tissue was found a fragmented wall

of artery about 4 cms. in circumference with a markedly thickened intimal surface and a firm elastic wall.

Microscopic: Sections showed an artery, the wall of which was distorted due to focal thickening of the intima. The internal elastica is destroyed in one point, where the arterial wall becomes thin and dilated, having no tunica media at this point. There is also fresh organizing hemorrhage in the vicinity of the vessel.

Diagnosis: Aneurysm ruptured. Fig. 1.

Specimen II: Spleen weight 110 grams. 11 x 7.5 x 2.5 cms.

Microscopic: Acute congestion and pericapsular hemorrhage.

Incidence: The true incidence of these aneurysms is unknown. In the analysis of ten pathological surveys, Yang et al⁷ found an incidence of splenic artery aneurysm of 0.04 - 0.05 percent, being two to three times more frequent in the female as in the male. In a smaller series of cases restricted to patients over 60 years of age, Ferrari⁸ found 14 aneurysms in a study of 143 splenic arteries (10 percent). The condition occurs most frequently in the fifth and sixth decades of life. However, in a review of 237 cases by Owens and Coffey,⁹ 46 percent of the females were in the childbearing age



Fig. 1

and of these, 53 percent were pregnant at the time the aneurysms were found.

Etiological Factors

The exact cause of splenic artery aneurysm is unknown. Etiologic significance has been attributed to a variety of conditions, e.g., arteriosclerosis, emboli, congenital defects, syphilis, trauma, portal hypertension and pregnancy. Arteriosclerosis is cited as the most common factor; in cases reported in pregnancy congenital defects are mentioned most frequently. These aneurysms tend to involve the main trunk of the artery in roughly two-thirds of the cases, and the primary and secondary division of the artery in one-third. There is a wide variation in size, the largest reported being 15 cm. in diameter; in those cases related to pregnancy, the size has usually ranged from 2.0 cm. to 4.0 cm.

Symptoms: They may mimic any abdominal condition and may be divided into those occurring before and those occurring after rupture. Before rupture a common complaint is epigastric or left upper quadrant pain. This pain may have different characteristics and can precede rupture from a few minutes to many years. Radiation to the back is seen in some of the cases. Exercise may aggravate it. Symptoms can be intermittent with attacks of vomiting, indigestion simulating cholecystitis or peptic ulcer, loss of weight, anemia, diarrhea or constipation, and occasionally, dyspnea or syncope.

Acute symptoms with severe upper abdominal pain, repeated vomiting, pain in the shoulder, urge to defecate and collapse are danger signs and indicate rupture. In the so-called "double rupture," there is an improvement in the patient's condition for a period of time. The second hemorrhage, usually within 48 hours, is most likely to be fatal unless surgical treatment is carried out promptly.

Signs: These will change depending upon the type of condition — whether or not the aneurysm has ruptured. The spleen and some other mass (most likely a hematoma) may be palpated in the left upper quadrant. It is important to auscultate the abdomen; a bruit may be heard. Following rupture, signs are those of shock, and blood in the peritoneal cavity, causing peritoneal irritation. Many of these patients will stop bleeding or bleed at a rate at which vital signs

can be maintained by transfusion before a second large hemorrhage and certain death occurs.

Diagnosis: It is symptomless until the effect on neighboring viscera or contiguous structures is manifest or until rupture occurs. The most important factor is awareness on the part of the physician concerned. In about 77 percent of Moore and Lewis¹⁰ cases, diagnoses were made by X-rays when the lesions were not suspected. The shadow seen by X-rays is characteristically an oval or round radio-opaque density in the left upper quadrant, and usually there is a ring of calcification. Calcium may be seen on occasion in the splenic artery. Demonstration may be done by means of translumbar aortogram. More often it can be demonstrated and with less danger by the intravenous aortogram. The differential diagnosis of this oval calcification should include calcified aneurysm of the renal artery, Echinococcus cyst of the mesentery, liver, spleen or left kidney and calcified mesenteric lymphnodes.

Course and Therapy

Prognosis: It is difficult to predict. In those patients in whom the aneurysm is found incidental to X-rays, mortality should be minimal. In those in whom operation is done after rupture, mortality can be considerable, even as high as 46 percent. In pregnant women, mortality can be even higher.

Treatment. Surgical treatment is the choice; proximal ligation of the splenic artery is useless; a splenectomy is not necessary as the organ will be maintained by collateral circulation or will become fibrosed. It is preferable to excise the aneurysm. However, a proximal and distal ligature may be sufficient for treatment. If the patient is a good risk, complete removal of the splenic artery with splenectomy is preferred.

Summary

The history of splenic artery aneurysm is presented. Another case report is added to the literature. Surgical treatment is the choice in all symptomatic cases, and in those who are asymptomatic and who are good surgical risks.

(Continued on page 341)



THE VIEW BOX

By LEON LOVE, M.D.
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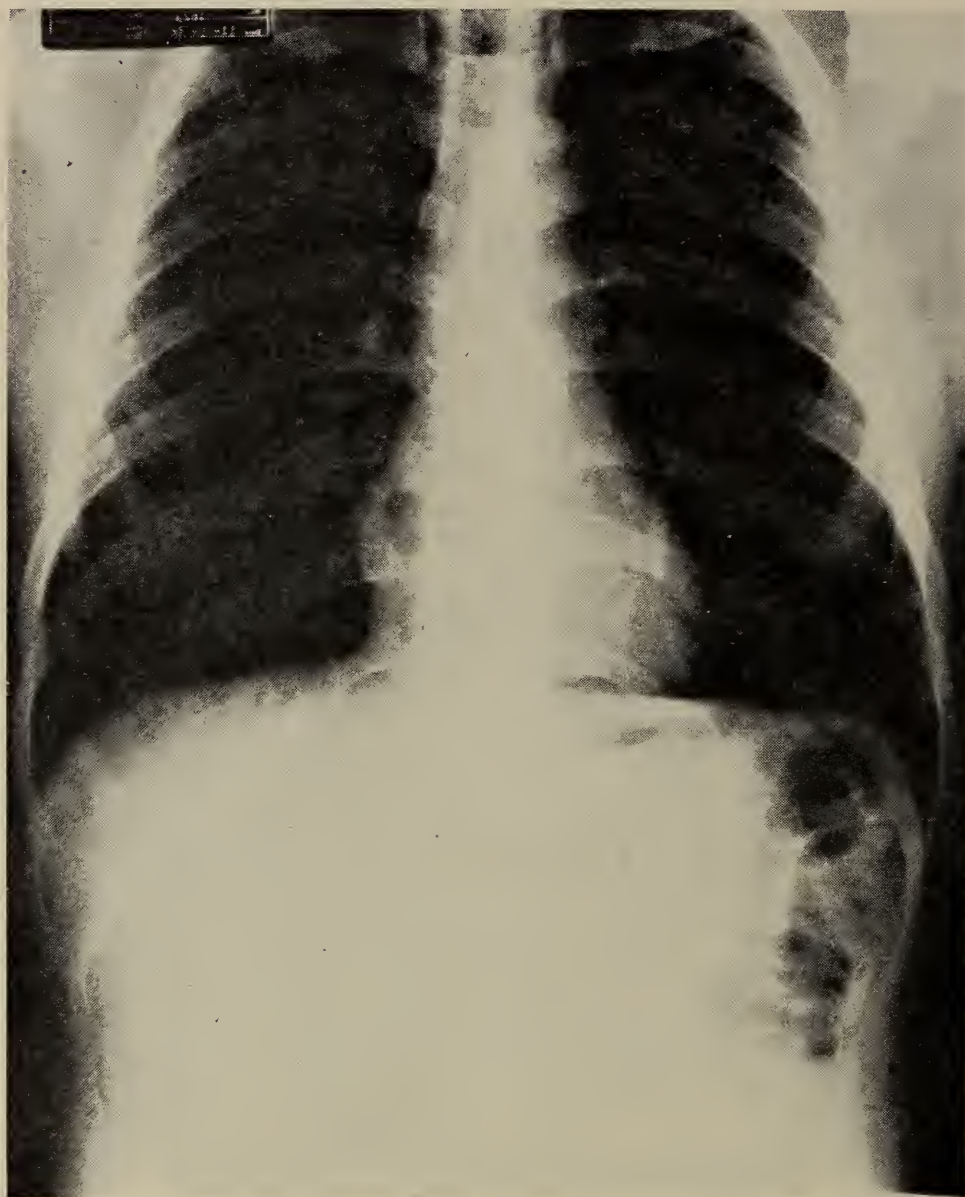


Fig. 1.

This 34-year-old male entered Cook County Hospital for repair of a right inguinal hernia. A routine pre-operative chest revealed an abnormal density along the right border of the heart. No other findings were present. WHAT'S YOUR DIAGNOSIS?

- 1) Scimitar sign of anomalous venous drainage.
- 2) Scar calcification.
- 3) Foreign body.
- 4) Intra-thoracic rib.

(Answer on page 354)

Pre-Operative Medication With Rectal Pyrilamine-Pentobarbital

By ROSS SCHLICH, M.D., DONALD CLARK, M.D.

AND EDWARD EVENSON, M.D./SPRINGFIELD

The anesthesiologist and surgeon have long been plagued by the dilemma of surgical premedications which work at cross-purposes. The ideal agent is one which reduces the patient's apprehension and, at the same time, modifies the vegetative nervous system so that undesirable reflexes are controlled. One reflex that has been a constant source of concern is nausea and vomiting. This phenomenon is so frequently considered an integral part of surgery that it is uncommon to regard it as a complication unless the consequences are dire. Gastrointestinal disturbances such as nausea, retching, and vomiting may constitute significant post-operative problems, but prophylaxis is not often emphasized and symptomatic measures are usually initiated in the recovery room after the problem is established.

The present double-blind, placebo-controlled study was undertaken to evaluate the effectiveness of pyrilamine maleate-pentobarbital rectal inserts for premedication with particular focus on the prevention of nausea and vomiting. There were several intriguing facets in the use of this drug combination. Pentobarbital sodium in moderate dosage suppresses the vomiting center itself, and, at the same time, provides sedation.¹ Pyrilamine maleate is an antihistamine of the ethylenediamine family, which are highly effective histamine antagonists with weak central action, and without the reputation of the piperazine group for countering motion sickness.² The insert under study has been used successfully in pediatric nausea and vomiting with telling effect.³

The rectal route of administration is not new in surgery, but has been used mostly in children. Piserchia,⁴ Smith,⁵ and Wallace⁶ used promethazine suppositories preoperatively to produce sedation in children

and one of us has had experience in perforating seccal capsules for use as premedicant suppositories in pediatric anesthesia. We are not aware, however, of any published reports concerning the rectal administration of pyrilamine maleate or pentobarbital, separately or in combination, to reduce the problem of post-operative nausea and vomiting, and as an adjunct to preoperative sedation.

Materials and Methods

The efficacy of the pyrilamine maleate-pentobarbital rectal insert was compared with that of a placebo in a total of 553 patients. Patients included in the study were those routinely scheduled for general surgical procedures with the following exceptions. Children less than 16 years of age were excluded, as were those with a history of ano-rectal disease, drug sensitivity, or ketosis, and patients over 65. Surgical diagnoses varied and, except as noted above, were not considered in the selection of patients. The maximal anti-emetic effect of the drug preparation was estimated to occur within three hours after administration. For this reason, the results were not evaluated in any patient (whether on active drug or placebo) in whom the duration of anesthesia was longer than two hours. Medication was administered on a double blind basis 45 minutes to one hour prior to induction of anesthesia. A careful record of the incidence of nausea, retching and/or vomiting was kept for each patient during the recovery period.

At the conclusion of the study it was found that 281 patients had received the pyrilamine maleate-pentobarbital rectal insert whereas 272 patients had been given the placebo. A total of 71 patients had experienced gastrointestinal disturbances postoperatively. The distribution of these pa-

tients in active drug or placebo groups is shown in Table I.

Table I.

Distribution of Patients Exhibiting Gastrointestinal Symptoms		
	Pyrilamine-	Placebo
	Pentobarbital	
Total no. of patients	27	44
Men	5	13
Women	22	31
Average age (range)	43 (19-62)	41 (16-61)
Duration of Anesthesia*		
Average	74 min.	69 min.**
Range	20-110	30-120
Surgical procedure		
Dilatation and		
curettage	5	4
Cholecystectomy	3	3
Hernia repair	2	4
Hysterectomy	6	8
Dental	1	2
Laminectomy	1	3
Breast biopsy	0	3
Other	9	17

*Patients were excluded from analysis if the duration of anesthesia was longer than 120 minutes.

**Average and range based on 43 patients. The duration of anesthesia was not recorded in one case.

Since this was a double-blind study, neither the patient, nor the nurse who administered the drug, nor the physician observer, knew which patients had received the active drugs.

Premedication, with few exceptions, consisted of meperidine in 50 mg. doses. This dose was chosen because it is known to have a low incidence of nausea and vomiting in comparison with larger doses,⁷ and because we already had the statistics of a control group from a previous study who had received the same drug in the same amount.⁸ The administration of the supplemental meperidine impaired the evaluation of the sedative quality of the suppository and forced focus on the value of the insert as an antiemetic. Three patients on the placebo received morphine instead of meperidine, and four others were also given hydroxyzine. Anesthesia, in both groups, was induced in nearly all cases by thiopental sodium and sustained by fluothane, nitrous oxide and oxygen. Seven patients on the pyrilamine maleate-pentobarbital combina-

tion, and three on the placebo, were given methoxy-fluorane. A few others received ether, and one patient on the placebo was given spinal anesthesia.

The pyrilamine maleate-pentobarbital rectal insert was administered immediately prior to transfer to the operating suite. The placebo was similarly administered. The rectal insert used in the patients on the active drugs contained 50 mg. of pyrilamine maleate and 100 mg. of pentobarbital sodium.

Results

Nausea, retching or vomiting was observed in 10 percent of the 281 patients who were given the pyrilamine maleate-pentobarbital rectal insert, and in 16 percent of the 272 patients who received the placebo. On the basis of Student's "t" test, the difference between the incidence of symptoms on the active drugs (10 percent) and on the placebo (16 percent) was statistically significant at the 0.02 level of probability. The 16 percent incidence in the placebo group was the same as observed in a control group of about 700 patients in a previous study receiving the same premedication (meperidine 50 mg. and atropine 0.4 mg.), within the same age limits, subjected to similar surgery and the same kinds of anesthetic drugs.⁸

In addition to the difference in incidence, there was a tendency for gastrointestinal disturbances to persist longer in patients receiving the placebo than in those on the active drugs.

The incidence of nausea and retching after more than one hour in the recovery room was higher on the placebo than on the active drugs. In those patients exhibiting gastrointestinal symptoms, vomiting persisted for more than one hour in 12 percent (5) of patients on the placebo and in 11 percent (3) of patients on the pyrilamine maleate-pentobarbital combination. This would seem to indicate that the medication acts prophylactically, but has little or no effect on vomiting with onset after peak time of effect is past. On the other hand, these patients may represent the 4 percent or less of the surgical population which some investigators contend are problem vomiters and who respond poorly to all treatment.⁹ In this study the 11 percent and 12 percent of patients vomiting more than 1 hour actually represent only 1.5 per-

cent of the 528 cases studied. This low incidence of problem vomiters could be due to the small dose of meperidine used, the wholesale employment of fluothane which is relatively inoffensive in provoking nausea and vomiting,⁷ to the age and time limitations imposed, and perhaps due also to the high experience age of our staff.

There were no observed side effects of any kind attributable to the use of the pyrilamine-pentobarbital rectal insert. In particular, there was no delay in the recovery of consciousness, no arterial hypotension, extrapyramidal reactions, respiratory depression, or effect on heart rate.

Discussion

The combination of pyrilamine maleate with pentobarbital contributed significantly to the reduction of postoperative nausea, retching and vomiting. In addition to reducing the incidence of these adverse effects, the active drugs also showed a tendency to shorten the duration of those reactions when they did occur. There were no significant side effects of any kind.

In view of these results, we believe that pyrilamine maleate-pentobarbital rectal inserts administered pre-operatively are of clinical benefit both as a sedative in the pre-operative period as well as an anti-emetic postoperatively. It is the opinion of many anesthesiologists that the routine use of an anti-emetic is hardly justifiable in pre-medication.¹⁰ However, for those advocates of non-narcotic sedation, the use of the pyrilamine maleate-pentobarbital insert achieves a desirable additional effect: a significant reduction in nausea and vomiting without compromising vital functions.

It is generally understood that gastrointestinal disturbances post-operatively may result from a variety of causes. The two groups of patients described in this study were closely comparable. Surgical diagnoses, though varied, were similar in both groups. Premedications and anesthetic drugs were also closely comparable. The only limitation imposed was that of duration of anesthesia, and this limitation applied to patients on the placebo as well as those on the active drugs. It is evident, therefore, that the differences in gastrointestinal symptoms seen in the results were the consequence of the anti-nauseant effect of the drug.

Summary

A total of 553 surgical patients was selected to assess the effects of a pyrilamine maleate-pentobarbital rectal insert in reducing postoperative nausea, retching, and vomiting. A double-blind, placebo-controlled approach was used. Two hundred and eighty-one patients received the active drugs (50 mg. of pyrilamine maleate and 100 mg. of pentobarbital) and 272 patients were given the placebo pre-operatively. Nausea, retching, or vomiting occurred in 27 patients (10 percent) on the active drugs, and in 44 patients (16 percent) on the placebo. This difference was statistically significant. In the patients studied, there was 37 percent less nausea and vomiting in the medicated group than in the control group. There was also a tendency for adverse gastrointestinal reactions when present to be of shorter duration on the pyrilamine-pentobarbital combination than on the placebo. There were no side effects of any kind. The medication was compatible with all anesthetic agents employed. The results of the study suggest that this combination may accomplish a dual purpose by reducing the incidence of nausea and vomiting in the post-operative patient and by acting as a safe and useful pre-operative sedative.

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Adult "Internal" Hydrocephalus

By R. F. HERNDON, M. D., AND ROBERT HAYNER, M. D. / SPRINGFIELD

Children with hydrocephalus are readily discovered and treated. An adult disorder is similar and is similarly treated.^{1, 2} It is not so easily discovered. Four cases follow.

Case 1.

This 37-year-old man was admitted with headache, 22 pounds weight loss, and thirst, all for four weeks. He had had one episode of unconsciousness walking to his house from his garage. He was seen during this episode by his wife and was noted to stiffen and shake all over. Since then he had been weak in his left leg. His appetite had been good, but he had had nausea and vomiting. He had usually drunk very little water, but during the previous six weeks he had drunk from six to eight glasses of water a day. Fifteen years earlier in the Army he had had a head injury treated with one suture.

Physical examination revealed a blood pressure when supine of 112/70 with a pulse of 74. When erect the blood pressure fell to 85/50 and the pulse rose to 90. Physical examination was entirely within normal limits except for evidence of recent weight loss.

Routine laboratory work was normal. The hemoglobin was 16.75 gm. percent, the hematocrit 48 percent. Spinal fluid examination was done showing a protein of 37 mg. percent, serum sodium, potassium, bicarbonate, chloride and sugar were normal; 24-hour urine 17 ketosteroids were 6.7

mg. per 24 hours, 17 hydroxycorticosteroids were 20 mg. percent per 24 hours. A Protein Bound Iodine was 6.8 micrograms percent. X-rays of the skull and chest were normal. A pneumoencephalogram performed by spinal puncture showed fractional filling of the ventricles.

Hospital course: the posterior fossa was explored with no abnormality discovered. The following day the wound was reopened. No clot was found but the dura was thought to be "too tight." A trial of cortisone resulted in temporary and symptomatic improvement but the patient's course deteriorated and he became somnolent; the pulse slowed to 36. Lumbar puncture revealed yellow fluid under a pressure of 120 mm. of water. Two days later the pressure was 110 mm. of water and the fluid was grossly bloody. A ventriculoatrial shunt was done. Subsequent to this he made an uneventful convalescence. He has rapidly regained weight and strength and is currently asymptomatic.

Case 2.

This 50-year-old man was admitted to the hospital first on Nov. 2, 1959, with the abrupt onset of chills, fever to 105 degrees and sore throat. With this he developed a generalized erythematous rash. He was treated with salicylates and penicillin without benefit. Throat cultures revealed a staphylococcus aureus coagulase positive. Many antibiotics were used. On Nov. 18 he developed evidence of a left otitis media and purulent sinusitis. On this date he had the abrupt diminution in hearing in his left ear. He was discharged on Nov. 23 with evidence of continuing inflammatory process in his left ear and a temperature of 101 degrees.

His second admission was on April 25, 1963, because of ataxia. He had been well until the summer of 1962 except for per-

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sistent deafness in his left ear. In that summer he had developed dizziness with occasional vomiting, especially on arising. On several occasions he had had dizziness on upward gaze.

Physical examination revealed a wide based gait. With standing, either with his eyes open or closed, and with his feet close together, he fell backwards and to the left. There was mild nystagmus on right lateral gaze and a coarse nystagmus on left lateral gaze. The left pupil was slightly larger than the right. There was a mild left peripheral facial paralysis. Routine laboratory work was not unusual. No ventricular filling was seen with a lumbar pneumoencephalogram. Spinal fluid protein was 100 mg. percent. Skull films showed evidence of a destructive process of the lateral portion of the left petrous ridge. Ventriculography and craniotomy showed dilation of the lateral third and fourth ventricles with obstruction of the outlet of the fourth ventricle due to scar tissue. Subsequently a Torkildsen shunt operation (ventriculocisternostomy by tube) was done. Progressive improvement followed.

Case 3.

This 66-year-old man was hospitalized with hypertensive and arteriosclerotic cardiovascular disease, osteoarthritis, bilateral hernias, partial deafness. He had had two episodes of congestive heart failure, the first in May and the second in June, 1967. In August, 1967, he was readmitted to the hospital because of vague abdominal pain and blackouts. On the day before hospitalization, he was found on the floor, unresponsive and dyspneic. Examination revealed a confused, middle-aged man. The blood pressure was 150/70, pulse 80 and regular and the general features of the neurologic examination were normal except for confusion. The deep tendon reflexes were brisk and symmetrical. No lateralizing signs were noted.

Laboratory studies revealed hemoglobin 12.6 gm. percent; hematocrit 39 percent; white blood count 5,850 with 3 percent eosinophils, 6 percent non-segment neutrophils, 53 percent segmented neutrophils, 35 percent lymphocytes, 3 percent monocytes. Urinalysis specific gravity 1.017, pH 7; albumin, sugar negative. Microscopic examination showed occasional WBC's.

VDRL non-reactive. Spinal fluid examination showed 23 mg. percent protein, 7 WBC's per cubic mm., all lymphocytes. The blood urea nitrogen 7.3 mg. percent; blood CO₂: 29.7 meq/L.; blood chloride 19, 6.7 meq/L.; Potassium 3.5 meq/L.; Sodium 141 meq/L.

An EEG was mildly abnormal with small sharp spikes.

Confusion persisted. Aug. 28, 1967, six days after admission to the hospital, a pneumoencephalogram was done which showed marked dilatation of the entire ventricular system. Three days later, a Spitz-Holter shunt was done but confusion persisted. Two weeks later he was transferred to a nursing home without evidence of improvement in that interval.

Case 4.

This 78-year-old woman was admitted to the hospital because of inability to walk with a tremulous feeling, nocturia three to four times a night, dryness of the mouth, non-productive cough. Her symptoms began in 1964. In March, 1966, incontinence of stools had appeared only to subside after a short period. Since then there has been progressive loss of use to the legs and a nervous shakey feeling.

Physical examination revealed a slightly confused, elderly woman. Examination was negative, except for the following: blood pressure 180/112; the heart and lungs seemed normal. Neurologic examination revealed marked lack of coordination with loss of proprioceptive sense in the lower extremities and diminished vibratory sense in the lower extremities. There were bilateral extensor toe signs and brisk deep tendon reflexes in the lower extremities.

Laboratory studies revealed the following: Urine specific gravity 1.014, pH 8, albumin, sugar negative; microscopic, occasional WBC's. BUN 10 mg. percent. VDRL non-reactive. WBC 7,950 with 4 percent eosinophils, 2 percent non-segmented neutrophils, 58 percent segmented neutrophils, 29 percent lymphocytes, 7 percent monocytes, hemoglobin 15.4, hematocrit 47 percent.

On the 8th hospital day, myelogram was performed. The subarachnoid space of the spinal cord was entirely within normal limits. Two days later, a pneumoencephalogram was performed which showed hydro-

cephalus with marked dilatation of the lateral and third ventricles. A small amount of air was demonstrated in the fourth ventricle which also appeared to be dilated. No air was shown in the cerebral subarachnoid space. There was no evidence of shift or deformity to the lateral ventricles.

A week later, a Spitz-Holter Shunt was performed. Subsequently, the patient slowly improved.

Discussion and Conclusions

Our four patients and others^{3, 4} presented as vague problems of neurologic or metabolic origin. This is essentially a mechanical problem^{5, 6, 7} and any therapeutic maneuver not reducing intracranial pressure fails. Before the introduction of shunting procedures, it did not matter whether the diagnosis was made or missed. Now these patients die if missed and may recover if treated surgically. In addition, hydrocephalus may develop or be present with "normal" pressure, at least as commonly measured.

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June AMA Convention—'Keeping Up'

Demands placed upon the American health care system have made the health services industry the nation's fastest growing employment field, American Medical Association president Milford O. Rouse, M.D., pointed out in a year-end report.

"Fifteen years ago it was the fifth largest employer, now it is third," said Dr. Rouse. "If present trends continue, it will become the nation's No. 1 employer by the early 1970s."

Few physicians need instruction in the facts concerning increasing demand.

In addition to the growing claims upon him by patients, medical society, hospital, civic affairs, and family, the physician faces his responsibility to himself to "keep up" with medical developments.

The year-around task of "keeping up" is manifested by the stack of medical journals, which is regularly attacked but often seems to be self-regenerating.

Once a year, the physician has an opportunity to spend the better part of a week doing nothing but "keeping up" at the

world's largest medical meeting, the Annual Convention of the American Medical Association.

The 117th Annual Convention of the AMA will be held June 16-20 this year in San Francisco. The Civic Auditorium, War Memorial Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advance malignant disease.

Four General Scientific Sessions will be presented and the 23 Scientific Sections will offer programs individually, many holding joint meetings on subjects of common interest.

Diabetic Dermadromes

By THEODORE CORNBLEET, M.D., Ph.D./CHICAGO

The interdependence of skin and the rest of the body is particularly well shown by the diabetic integument. Numerous cutaneous changes emphasize this tie. Some of these alterations are positive evidence that diabetes is present, while others portend its later development. Recognition of these dermal lesions for what they are will permit earlier care of the basic disease. In turn, control of the diabetes may help to clear the skin lesions themselves. Some of these dermatologic manifestations of diabetes have long been known, others are recent discoveries, while still others are undoubtedly still to be recognized. Some are common, others rare; a few are obligatory to the diabetic state, while the rest are non-specific. Cutaneous symptoms and signs may be present with diabetes, however unrelated to it. This review does not purport to detail all diabetic dermadromes recognized, accepted, or suggested but will list those better known, more common, or firmly established.

The most common diabetic dermadromes are due to pyogenic infections—folliculitis, furunculosis, carbunculosis, and cellulitis. Next most common is monilial infection of skin and mucosal folds, especially the female external genitals. Pruritis is the most

common symptom and most often affects the female pudendum. Diabetes may severely compromise blood vessels and circulation, even causing gangrene. The lipoidoses, e. g., several varieties of xanthoma, are colorful, though uncommon. Besides the foregoing, many less important cutaneous warnings and sentinels of diabetes are known.

Pyogenic Infections.

Folliculitis of the hairy parts, such as around the genitals, axillae, nostrils, and eyelids, results most often from rubbing and scratching. These perifollicular papules and pustules may enlarge to become *furuncles*. The latter may occur wherever there is hair, including the glabrous skin. Especially at the vulva and male neck, infection of several contiguous follicles may develop into a *carbuncle*. This is always a serious lesion. Cleanliness, anti-obesity and diabetic measures will reduce pyogenic lesions almost to the vanishing point. Their presence is probably encouraged by increased sugar concentrations in and on the skin. Fasting skin sugar is about 60 percent of blood levels in normal people but in the diabetic it is approximately 70 percent. Skin glycogen, on the other hand, is below normal levels before antidiabetic treatment.



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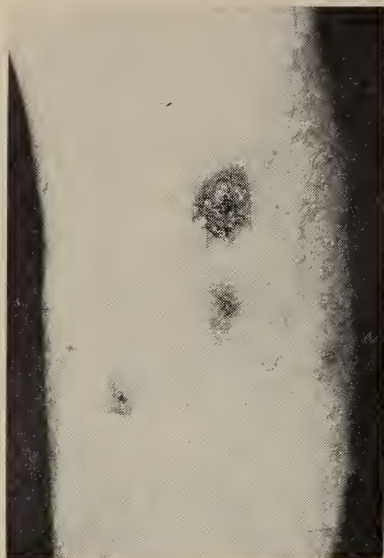


Fig. 1. Ecthyma.



Fig. 2. Furuncle in diabetic.

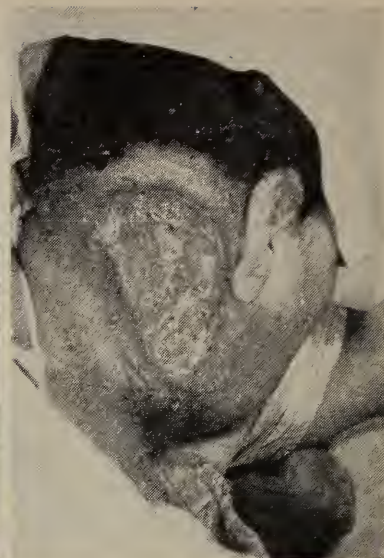


Fig. 3. Carbuncle (glycosuria).

Early treatment of minor infections will curb these pyogenic aggressions. Guided by laboratory indications, use of proper antibiotics and corrective metabolic measures will almost always control what once were formidable staphylococcal infections. Surgery, except to evacuate trapped pus pools, is not indicated. Where infections recur search for a nidus, such as in the nose, or in a nearby carrier, may end these repeated bouts.

Pruritus.

Itching is the diabetic's most common symptom, especially around the genitals in females. Sugar-laden urine, monilial infections, and breaks in the skin induce itching. Rubbing and scratching traumatize, aggravating the pruritus. Persistent and resistant itching at any orifice—eyes, mouth, ears, nose, anus—suggests a diabetic background. Secondary pyogenic infections follow and they too hint of diabetes. Sponging the area after urinating prevents sugar

accumulation and stagnation. Steroid applications are anti-pruritic and comforting. A cleansing douche, too, brings some relief. Lastly, sedatives, especially those that are anti-pruritic, soothe; a soporific may bridge a pruritic nightmare; and of course, control of the diabetes is mandatory.

Monilial Infections.

These are, perhaps, the most common diabetic sequels that the dermatologist sees. Moist folds and orifices are favored parts—the mouth and female genitals, and inframammary, axillary, interdigital, and perianal areas. The involved vulva is slightly swollen and tender and shows a reddish-blue color and grayish surface. There is compulsive scratching, leaving excoriations and much discomfort. The moist surfaces of the labia are first involved and from here extension takes place to the mons and even the lower abdomen above and posteriorly to the anus, and to the gluteal and crural folds. Whitish pellicles harboring growths of monilia are present on the mucous surfaces. The same measures used for pruritus valvae help for moniliasis, with addition of topical nystatin or amphotericin B preparations.

Balanitis.

While diabetes causes inflammation and pruritus of female genitals more often than male counterparts, balanitis is nevertheless an occasional complication. In the circumcised, it is almost nonexistent.

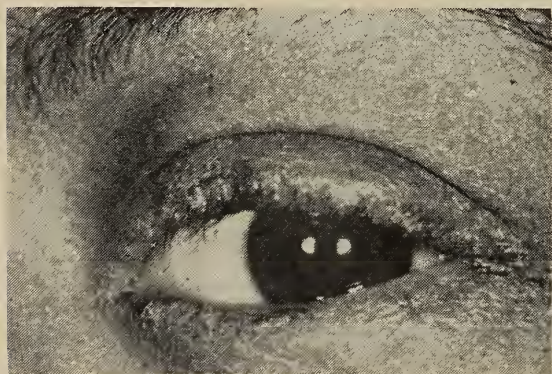


Fig. 4. Blepharitis in diabetic.

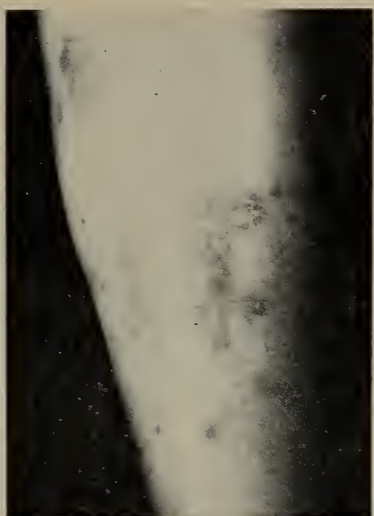


Fig. 5. Necrobiosis lipoidica diabeticorum.



Fig. 6. Xanthoma diabeticorum.

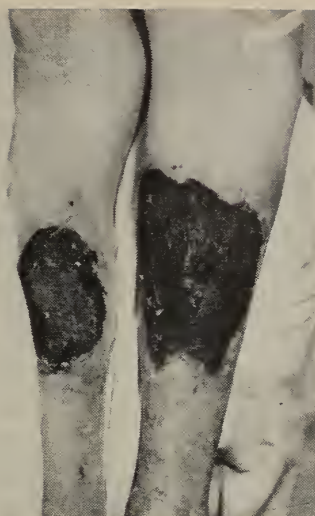


Fig. 7. Gangrene in diabetic.

Tinea Infections.

The ordinary superficial fungus infections (tinea, ringworm) are no more common in diabetics nor are they worse than in nondiabetics. The same measures are employed as in nondiabetics. The antifungal antibiotic, griseofulvin, is nondiabetogenic.

Gangrene.

One of the more important diabetic complications, this is due to vascular occlusion. Even when rigidly controlled, diabetes leads to a more or less inexorable atherosclerosis. Still unknown is the factor, other than the basic carbohydrate derangement of diabetes, responsible for intimal corrosion of blood vessels. Occlusion of an end artery leads to necrosis and gangrene. In diabetics the lower extremities or their subdivisions are most likely to be affected. Even with a compromised circulation, scrupulous hygiene and care of the feet, toes, and toenails will help prevent gangrene. Absence of the dorsalis pedis pulse, color of the

raised and lowered foot, and temperature at various levels of the lower extremity are rough indications of possible impending gangrene. Since vascular occlusions in diabetes may be localized and sectional, gangrene of an isolated part, such as the toe, may occur despite other indications of soundness of the extremity. The care of impending and manifest gangrene, however, is the province of the vascular and general surgeon.

Trophic Ulcer.

This lesion is probably not due to ordinary gangrene, but to some nerve disturbance. It occurs most frequently at pressure points, such as under metatarsal heads. Well fitting shoes, weight reduction, and care of hyperhidrosis and fungus infections are preventive measures that may favor healing. Sometimes grafting succeeds after proper preparation of the ulcer base. Diabetic neuropathy may make early gangrene, infection, and ulceration painless and thus remove early warning signals.

Localized Lipodystrophy.

At times this follows multiple and repeated insulin injections at one site. The lesion feels like an empty space and is depressed. It is symptomless and not serious. Choice of alternate and multiple injection areas may be preventive, and after several months lost subcutaneous tissue may be restored. No other measure is known to prevent or cure this atrophy. *Lipomas*, too, may develop following insulin injections but are rare. They are benign and inconse-



Fig. 8. Monilial infection of tongue.

quential. *Progressive and generalized lipodystrophy* affects the subcutaneous fat, mostly of the head and thorax, and most often in women. There is atrophy of the panniculus, and it is associated with hyperlipemia and hepatomegaly. Later there is portal cirrhosis and hypermetabolism with euthyroidism. Presence of these atrophies should arouse suspicion of the presence of diabetes.

Lipoid Diseases.

Xanthelasma. This, the most common of the lipoidoses, should perhaps not be classified as a diabetic dermodrome. It forms chamois-colored patches on the eyelids, and hypercholesteremia may or may not be present. When diabetes exists, however, blood cholesterol is more apt to be elevated. The lesions start as small papules and grow or coalesce to form outlined, symptomless patches, lasting indefinitely. Cautery, some destructive method, or excision are the only methods that will remove these lesions. A low cholesterol diet may prevent or slow their return.

Xanthoma Diabeticorum.

This lipoidosis is secondary most often to uncontrolled diabetes, hyperlipemias, and hypercholesteremia. Eruption occurs suddenly with hard, discrete, single or grouped nodules and papules favoring elbows, knees, and buttocks. Other areas involved are trunk, hands, fingers, and tongue. Lesions are discrete cones with yellow summits and reddish bases. The palms may be yellowed and their creases are traced by bands of deeper yellow. There may be itching, and lipemia retinalis is sometimes associated. After controlling the underlying diabetes, the eruption clears spontaneously without scarring.

Necrobiosis Lipoidica.

This, the most recently recognized lipoidosis occurs most often in diabetics or members of diabetic families, and more frequently in women. The skin develops necrobiotic areas that become infiltrated with a complex protein of uncertain composition. Most commonly they form over the shins or malleoli, evolving from red, firm papules until characteristic plaques form. These have yellowish, waxy, telangiectatic, depressed centers bordered by red to violet zones. Ulcers may form that heal

slowly or not at all. The intact lesions are symptomless and stay on indefinitely in spite of all treatment, though intralesional steroid injections are said to be of benefit.

Xanthochromia or Carotenemia.

A yellowish tinting, especially of the palms, soles, and nasolabial folds, is less common in diabetics than formerly. Due to accumulation of lipochromes, mostly carotene, a vitamin precursor, the discoloration has little significance. Diets using excesses of carrots, sweet potatoes and corn, and egg yolks and butter often used in diabetic diets, coupled with faulty utilization, destruction, or excretion of carotenoid pigments explain the discoloration. Not to be confused with jaundice, xanthochromia leaves the sclerae clear, and bilirubin levels are normal. Reducing intake of xanthic foods, easily possible with modern diabetic management, will slowly clear the discoloration.

Hemochromatosis or Bronze Diabetes.

This disorder of iron metabolism causes a kind of diabetes and pigmentation. There are shades of swarthinness, especially of exposed parts, but skin folds, breasts, and perineum, too, are darkened. The discoloration is due to increased deposits of pigment and iron products, such as hemosiderin. Skin biopsy sometimes is diagnostic but if not, that of the liver is. Minimal iron diet and systematic blood-letting reduce iron stores but not enough to cure the diabetes, which is due to ferrous accumulates in the pancreas and elsewhere. Of course, standard measures for diabetes, in conjunction with other procedures, are required.

Cheilosis.

In diabetes this is not rare. In uncontrolled diabetes, heavy tartar deposits are frequent, together with tender, swollen, bleeding, or abscessed gums. The tongue is dry, fissured, and coated, and thrush is fairly common.

Dupuytren's Contracture.

This mostly affects male diabetics by involving the palmar fascia. Deformity is usually mild and seldom requires correction.

Hirsutism.

Fine lanugo hair sometimes covers the



Fig. 9. Onychomycosis (monilial).

back and arms of young malnourished subjects with uncontrolled diabetes. Regression of this growth follows diabetic control.

Shin Spots.

These are round, linear, or irregularly shaped, coin-size, discrete areas over the anterior surfaces of legs. They usually are hyperpigmented, depressed, and atrophic. They often resemble remains of old injuries. Such burnt-out lesions may often be seen in diabetics.

Abnormal Sweat Patterns.

These have been described as a manifestation of autonomic nerve involvement in diabetes. Such patients do not tolerate heat, and sweat excessively from the waist up in warm weather and especially at night; below the belt line the skin is dry.

Porphyria.

This disturbance has a greater incidence in diabetics, but in males only. It supposedly is due to iron accumulations or lack of enzymes containing an iron protoporphyrin prosthetic group.

Diabetic Charcot Joint.

This disease is probably due to diabetic neuropathy. Insensitivity to pain conduces to repeated trauma and joint destruction, or the neuropathy itself may account for articular regression.

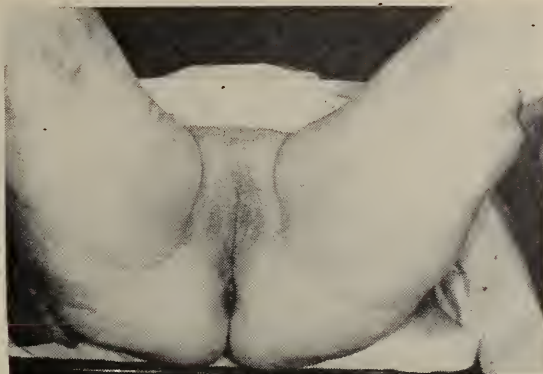


Fig. 10. Moniliasis (glycosuria).

Histological Changes.

The apparently clinically normal diabetic skin has larger numbers of mast cells in the upper dermis and around appendages.

Drug Eruptions.

Any of the oral antidiabetic medicaments may cause drug eruptions.

Immune Reactions.

A reciprocal relation exists between the degree of immune response and proneness toward infections conditioned by the level of glycemia. Hyperglycemias inhibit anaphylactoid reactions and potentiate infections; hypoglycemias, on the other hand, potentiate anaphylactoid reactions and inhibit infections. These effects are supposedly due to varying facility of antigen-antibody combinations.

Other disorders said to have a greater than usual association with diabetes are chronic paronychia, Kaposi's sarcoma, Werner's syndrome, lipoid proteinosis, psoriasis, palmer and planter hyperkeratosis, xeroderma, cutaneous para-, hyp-, and hyperesthesia due to neuropathy.

Conclusion

A number of cutaneous symptoms and signs are due to diabetes. Recognition of these permits the practitioner to suspect and diagnose the basic disease. Thus, he can prevent its progression and complications and better meliorate the skin.

**Make Plans Now to Attend
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A Suicide Prevention Center in Chicago

By FRANCIS M. PARKS, M.D. AND DARLENE WOLF, M.S.W./CHICAGO

Because suicide continues to be a major cause of death, organizations dedicated to the prevention of suicide have been developing throughout the United States. This development has occurred with increasing momentum especially during the past 10 to 15 years. This paper presents a report of the development and the first two years of experience of a Suicide Prevention Center in Chicago, under the name of Call For Help Clinic. As a result of this experience, we have certain general recommendations for the operation of such Centers which will be presented at the close of the paper.

Historical Statement.

Call For Help Clinic was organized in the end of 1964, and its subsequent development may be divided into three fairly distinct phases. The first of these might be referred to as the period of initial exploration and took place during the winter months of 1964-1965. Efforts during this period consisted of studying the pattern of suicidal behaviour in the Chicago area and the way in which suicides and suicidal attempts were handled. These efforts were carried out with the co-operation of the Cook County Coroner's Office, Chicago Board of Health, and several of the Poison Control Centers in Chicago. In addition,

discussions were had with the administrative and professional staffs of Cook County Hospital and also of three private hospitals in Chicago's northside. The latter were selected because they were believed to be located in an area of high incidence of suicidal behaviour.

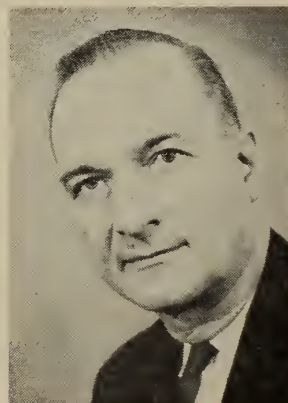
The second historical phase began perhaps in February or March of 1965 and continued for somewhat over a year. During this phase our objectives were to gain clinical experience with suicidal people, to make our Clinic known to various organizations with whom we expected to co-operate, and to promote educational activities in relation to suicide and its prevention.

To gain clinical experience we asked hospitals to refer to us suicide attempters, following the emergency management of their self-inflicted injuries. Cook County Hospital provided the greatest number of these referrals. The Pediatric Division of Cook County Hospital showed a greater interest than other departments in referring patients to us, with the result that we had a disproportionate number of children and adolescents in our case load. With the co-operation of Cook County staff, Call For Help staff frequently saw patients while still in the wards of County Hospital, to evaluate the appropriateness of their referral to Call For Help following discharge.



Francis M. Parks, M.D., is a graduate of the University of Kansas (pre-med) and Tulane University (M.D.). He is presently engaged in the private practice of psychiatry in Chicago. Prior to this he served in the field of general practice in Georgia. His rotating internship was at the USPHS Hospital, New Orleans, and he has served a psychiatry residency at Northwestern University and the Downey V.A. Hospital.

Darlene Wolf, M.A., a Mental Health Consultant with the Head Start Program in Chicago, assisted in the research project on the suicide prevention center. She is a graduate of Loyola University, Chicago, and has served as a clinical social worker for five years.



Seeking to make ourselves known to community organizations, we contacted the Illinois Department of Public Health, various psychiatric hospitals and out-patients clinics, and social service organizations. Contacts were also had with the Chicago Police and Fire Departments.

For educational purposes, efforts were made to present talks to various groups within the city. These talks were presented by members of Call For Help staff to classes in several local colleges, to religious groups, and to professional organizations. In December of 1965 a special one-day conference on suicide and its prevention, jointly sponsored by Call For Help Clinic and the Chicago Board of Health, was presented at the University of Chicago. This conference was attended by over 100 people, mostly professionals. At this time, educational efforts stressed the problems of suicide in the community and sought to develop professional and public support for the developing suicide prevention center; we were careful not to make offer of our services to the public, since at that time our Clinic was open only on a basis of five days a week, during office hours.

The third phase of Call For Help operation can be dated from July 1, 1966, on which date for the first time an around-the-clock, seven-days-a-week, telephone coverage* was provided with the plan of offering help to people who would contact us by telephone. In addition, provision was made to offer out-patient services to walk-in cases, also on an around-the-clock basis. The regular out-patient clinic activities were expanded to include appointments with persons who had contacted the clinic by telephone, where this seemed appropriate.

Throughout the six months period following the opening of around-the-clock coverage, publicity was sought with increasing intensity to acquaint the public with the services available through Call For Help Clinic. This publicity was had through various presentations in the Chicago's newspapers, and on radio and tele-

vision. Due to this publicity, it was necessary to handle an increasing volume of telephone contacts as well as in-person clinic visits. Therefore, during our third phase of operation less emphasis was placed on referral of patients from hospitals following suicide attempt.

The staff of Call For Help had somewhat gradually increased in size during the developmental phases described, and during the third phase consisted of three psychiatrists and a psychologist, all on a part-time basis, and a full time staff consisting of a psychiatric social worker, a nurse serving as a social case worker, a clinic-coordinator and a clerk typist. In addition, a group of ten to twelve medical students were employed on a rotating basis to cover the service at night and on weekends; the medical students were at all times supported by a back-up force consisting of the staff psychiatrists, social worker and case worker. The clinic co-ordinator, though without professional training, also developed considerable skill in dealing with people upset in time of crisis and has also served as a member of the back-up force.

Case Load—Development and Methods of Handling.

An understanding of the historical phases outlined above is necessary properly to evaluate the development of Call For Help case loads, both in terms of patients seen in the clinic and persons who made contact only by telephone. Prior to the third phase of development, Call For Help had sought to select its own patients as outlined above, and had specifically avoided any offer of services to the public at large. In spite of this our organization did gradually become known, and a slowly increasing number of telephone contacts from disturbed people was developing in the second phase and even in the first. Accompanying this report are a series of tabulations giving a breakdown of the statistics of our case load, both for in-person and by-telephone contacts.

Patients seen during the second historical phase were given a diagnostic work up consisting of social history, psychiatric examination and psychological testing. Afterward patients were handled in one of several ways. Our own clinic offered brief, crisis-oriented psychotherapy on an out-patient basis to a certain proportion of

* Because of fiscal and other administrative problems, the night and weekend coverage of this service was initially organized as a separate department of Stone-Brandel Center known as the Emergency Services Program (ESP). After about a month and a half of separate operation, Call For Help and ESP were merged to facilitate communications and record keeping with the staff as well as the training of staff personnel.

patients where this seemed appropriate. This therapy was limited in duration to no more than 4 to 6 weeks. Patients who needed long-term psychotherapy were referred to other psychiatric clinics, or to private therapists. In certain instances efforts were made to assist in restructuring a family situation or other source of social stress upon the patient. Referrals were also made to family service agencies and various other types of counseling.

During the third phase of operation, the same methods of handling patients seen in person in the clinic have continued; however, because of an increase in case load there has been a smaller proportion of cases given the complete diagnostic evaluation. Many of the patients seen in the clinic are seen only once and that by the social worker or case worker with an appropriate referral to another agency made following this single contact.

Telephone contacts have been handled in a number of different ways. The first effort of the telephone therapist is to evaluate the seriousness of the suicide threat or attempt and thus decide whether immediate intervention is necessary. Where such intervention is necessary, the assistance of someone present with the suicidal person has been sought, or if intervention by an outside party is necessary, the usual course has been to send the police to the scene. On a few occasions, personnel from Call For Help Clinic have gone to the scene to assist in the intervention. The vast majority of telephone contacts have been handled without such intervention being necessary. Many of these callers seemed to have been adequately helped by the initial telephone contact so that they have themselves decided upon a more appropriate course of action than suicide. Many turn out to be persons already in psychiatric treatment and these persons are referred to their own therapist, if no immediate crisis intervention seems necessary. Probably a third of the callers have been offered an appointment in Call For Help Clinic for the following day. A large proportion of these people have failed to keep their appointments; follow up, where it has been possible, has usually indicated that the person felt so much better by the time of his appointment that he thought it unnecessary to come in. A certain proportion of callers seem in no real emergency dis-

tress but in need of long-term psychiatric treatment; these persons have frequently been adequately helped by a referral to a source of such treatment. It should also be obvious that people have called with many types of more or less emergent problems not involving suicide. These calls have been handled essentially as were suicidal calls. In all cases, if the caller considered his problem an emergency we treated it as emergent at least until we could adequately evaluate the situation.

Results of Therapy.

As was expected, both from the experience of other clinics and from the limited extent of our own operation, there has been no evidence of a change in the suicide rate in the Chicago area following the opening of Call For Help Clinic. The vast majority of our telephone contacts have been of obviously low suicidal potential at the time of the call; there have been a few instances—probably no more than 10 or 12 in all—in which we feel that emergency intervention on the part of our staff was of real value in avoiding a catastrophe. So far as we are able to learn, no one has committed suicide during the acute period in which he sought help from our Clinic.

Many of our callers have become repeat callers. Some of these became such regular repeat callers as to be classified as "chronic callers." Clinic personnel have gradually become more effective in discouraging the chronic callers. Other repeat callers, however, have called only once in each period of upset, but have by their occasional repeat calls demonstrated that suicidal behaviour is a regular part of their functioning, whenever stress becomes great.

Follow-up of patients actually seen in the clinic has been somewhat more successful than that of telephone contacts, although even here leaving much to be desired. A review was made of follow-up results in the first 125 cases seen in the clinic; this follow-up involves a period of from two months to nearly two years. In slightly more than half of these cases—68 to be exact—no follow-up contact was possible. Of the 57 who were actually followed up, 11 indicated that they were doing well and needed no further assistance. The remaining 46 were either receiving psychiatric treatment or were being followed by a Social Service Agency. It seems a reasonable

guess that the 68 who could not be contacted included a rather large proportion of persons who still need further help.

Summary and Discussion.

A brief history of the organization and the development of Call For Help Clinic as a Suicide Prevention Center in Chicago has been presented, along with tabulation of statistics dealing with the services performed. No statistically valid conclusions are drawn from the data presented, except that the vast majority of telephone contacts have been from persons who were not seriously suicidal. In general our results tend to agree with those of other clinics and strongly suggest that suicidal behaviour short of actual suicide represents a *modus operandi* for many persons. Because of this we feel strongly that, while emergency intervention in time of crisis is important, the far more important contribution which

a Suicidal Prevention Center can make is in the area of research into the nature and causes of human self-destruction behaviour.

Two specific recommendations, for the future operation of Call For Help and similar clinics, seem obvious from the foregoing. The first is the urgent importance of coordinated efforts at follow-up of clinic contacts. The second is that more real understanding of human self-destructive behaviour will result from detailed and long-term study of relatively few cases, rather than simply collecting "statistics" of a larger number of contacts.

References

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Kostrubala, Thaddeus, M.D.: "Suicide in Chicago: A Call For Action," *Illinois Medical Journal*, July, 1966.

STATISTICS*

TABLE I		
Clinic Patients		
Month	1965 (April-Dec.)	1966 (Jan.-Dec.)
January	0	7
February	0	9
March	0	9
April	3	14
May	3	8
June	2	6
July	2	9
August	5	25
September	4	17
October	5	22
November	10	11
December	8	14
Totals	42	151**

TABLE II				
1965 Clinic Patients by Age, Race and Sex				
Age	White		Negro	
	M.	F.	M.	F.
9-13	0	2	3	3
14-18	1	3	2	3
19-23	1	5	1	6
24-28	1	1	0	1
29-33	1	1	0	2
34-38	0	3	0	0
39-43	0	0	0	0
44-48	0	1	0	0
49-53	0	1	0	0
	4	17	6	15
Totals	21		21	

TABLE III				
1966 Clinic Patients by Age, Race and Sex				
Age	White		Negro	
	M.	F.	M.	F.
4-8	0	0	0	3
9-13	2	1	2	9
14-18	7	9	8	14
19-23	4	7	1	17
24-28	7	7	2	3
29-33	3	11	0	2
34-38	1	5	0	0
39-43	2	3	0	1
44-48	0	4	1	2
49-53	1	3	0	0
54-58	2	1	0	0
59-63	2	2	0	0
64-68	1	0	0	0
	32	53	14	51
Totals	85		66	

TABLE IV	
Final Disposition of Clinic Cases-1965	
Withdrew from clinic	13
Out-patient psychiatric clinic	11
Public mental hospital	3
Social service agency	2
Community resources other than our clinic needed and available, patient not ready	2
Other psychiatric services	2
No given disposition	6
State mental institution	1
Psychiatric service general hospital	1
Private psychiatrist	1
Total	42

* Compiled by Jeanne Anderson, R.N., Darlene Wolf, M.S.W. and Joan Gray, Clinic Coordinator.

**This number does not include 67 walk-in patients, which would bring the total number of patients actually seen in 1966 to 218.

TABLE V
Final Disposition of Clinic Cases, 1966

Withdrew from clinic	23
Clinic terminated, further care not indicated at this time	17
Clinic terminated, resources other than clinic needed and available, patient not ready	16
State mental institution	6
Private mental institution	1
Public mental hospital	2
Psychiatric service general hospital	2
Private psychiatrist	11
Other psychiatric in-patient facility	2
Other out-patient psychiatric clinic	39
Private physician	1
General hospital	3
Other psychiatric services	1
Social service agency	16
Court, correctional institution, police, school	3
Additional Clinic services needed, patient not ready	7
Vocational rehabilitation	1
Total	151

TABLE VI Telephone Contacts				
Month	1965 (April-Dec.)	1966 (Jan.-Dec.)		
		D. Calls	N. Calls	
January	*	13	**	13
February	*	17	**	17
March	*	6	**	6
April	1	15	**	15
May	2	28	**	28
June	3	31	**	31
July	2	28	23	51
August	3	67	21	88
September	16	73	60	133
October	14	116	68	184
November	10	164	93	257
December	15	93	90	183
Totals	66	651	355	1,006

* Three month period of hospital and social agency contact to survey community need for Suicide Prevention Clinic.

** No night operations.

(Continued on page 334)

TABLE VII
1965 Telephone Contacts by Age and Sex

Age	Male	Female	Total
9-13	1	0	1
14-18	2	5	7
19-23	4	5	9
24-28	3	3	6
29-33	1	4	5
34-38	3	4	7
39-43	1	4	5
44-48	0	1	1
49-53	1	5	6
54-58	0	2	2
59-62	1	1	2
Unknown	4	11	15
Totals	21	45	66

TABLE VIII
1966 Telephone Contacts by Age and Sex

Age	Male	Female	Total
9-13	10	6	16
14-18	21	50	71
19-23	39	91	130
24-28	20	73	93
29-33	23	80	103
34-38	20	49	69
39-43	25	55	80
44-48	18	45	63
49-53	12	23	35
54-58	2	15	17
59-63	5	22	27
64-68	2	8	10
69-73	0	4	4
74-78	2	2	4
Unknown	62	222	284
Totals	261	745	1,006

NIMH Issues New Book on Psychoactive Drugs

Native drug practices, from prehistoric tribal rites to the contemporary psychedelic scene, are given historical perspective in a new book, "Ethnopharmacologic Search for Psychoactive Drugs," issued recently by the National Institute of Mental Health, U.S. Public Health Service.

The 450-page publication contains the proceedings of a symposium held early last year in San Francisco under the sponsorship of the Psychopharmacology Research Branch of the NIMH. Speakers from more than 10 nations met for the first time to exchange information and stimulate research in a field that professionals feel has been relatively neglected.

Although the use of plants or their extracts for medicinal and religious purposes is practically as old as the human race, this symposium was the first attempt to bring together international experts and to consolidate all presently available information. Participants were invited from a wide variety of scientific disciplines to discuss current progress and problems in the area of historical drug research.

One of the problems of research in this field is the difficulty encountered in tracing native drug practices back through history. As the science of drug chemistry has become more complex, the primary sources of these drugs have too often been

lost in obscurity. At the same time, the intrusions of civilization have progressively destroyed many of the original botanical sources. Thus, according to Dr. Daniel H. Efron of the Psychopharmacology Research Branch, who edited the book, "time is running out if we want to save this information, and perhaps use for medicinal purposes some of the unknown compounds contained in some of these plants."

Included in the book are chapters devoted to kava, snuffs, mushrooms and modern hallucinogenic agents as they have been used worldwide through the centuries.

Piper methysticum, or kava, is a beverage taken by South Sea Islanders as a social and ceremonial drink and plays an important role in their tribal folklore. Farther north, Venezuelan tribesmen still follow the same snuff habits that were first reported by Amerigo Vespucci in 1504. During his initial voyage to South America, Vespucci described the natives as "having cheeks bulging with a green herb which they chewed like cattle." Completing the global circuit, scientists also gave an extensive account of the Fly Agaric mushroom, used by several Russian tribes as an hallucinogenic agent.

In an address on "Perspectives on the Use and Abuse of Psychedelic Drugs," Dr. Daniel X. Freedman of the University of Chicago explained the interest of research scientists in finding links between native drug practices and the current use of hallucinogenic drugs.

"History does indeed record our unceasing urge to transcend limits and escape dreary reality or anxiety with the aid of magic, drugs, drama, festival rites, and through dreams," Dr. Freedman said. "Even though we could doubt that drugs produce pleasure without the risk of harm, and wonder if man is built to sustain and to manage more than a brief chemically induced glimpse of paradise, we must still examine the data of ethnology, pop culture and clinical data for real evidence," he says.

"For the future," Dr. Efron commented, "we must gather more information about these compounds used in native medicine and culture, and also discover the mechanisms of action. Such compounds are not only drugs, but are potential tools that may help us elucidate information as to how the central nervous system works."

Doctors Find Heart Damage Reversible in Recovered Alcoholics

The results of a five-year cooperative study by Chicago medical researchers may offer some hope to chronic alcoholics depressed by the belief that their drinking has caused permanent damage to their heart.

Dr. Paul B. Szanto, chairman of the department of pathology at Hektoen Institute for Medical Research, says he and a team of cardiologists under Dr. John R. Tobin, Jr., chairman of Hektoen's department of cardiology, have found evidence which reveals that the damage caused the heart by heavy and continuous alcoholic intake appears to be reversible to some extent when the patient stops drinking.

"Doctors have known for some time that chronic alcoholism causes serious damage to certain vital organs of the body, such as the liver, pancreas, and nervous system," Dr. Szanto said, "but it was not until we were able to study the nature of the early stages of damage through the use of the advanced electron microscope that we observed these significant changes in other organs, such as the heart. Ordinary microscopes were simply not powerful enough to allow us to see these subtle changes in the damaged organs. The careful clinical studies of our cardiologists permit the assumption that this damage may subside if the patient stops drinking completely."

"Studies with laboratory animals also proved the direct damaging effect of alcohol upon the heart," Dr. Szanto said.

Working on the Hektoen research project with Dr. Szanto and Dr. Tobin were Miss Katherine Larsen, Miss Barbara Miles, Dr. George S. Sutton, and Dr. Rolf M. Gunnar.

Their findings were presented by Dr. Szanto recently in a paper delivered before the American Society of Clinical Pathologists and the College of American Pathologists.

The research team of Dr. Szanto and Dr. Tobin received the Silver Award from the American Society of Clinical Pathologists and the College of American Pathologists, for their original exhibit, "Alcoholism and Primary Myocardial Disease—Light Microscopic and Ultrastructural Alterations in Human and Experimental 'Alcoholic Cardiomyopathy'."

Impartial Medical Testimony

By RICHARD OTT

Illinois State Medical Society Division of Scientific Services

The results of the experiment with a program for Impartial Medical Testimony in Illinois have been completely satisfactory. Funds for continuing use of the panel of experts have been included in the Supreme Court budget, \$12,000 having been allotted by the state for the biennium beginning July 1, 1967, bringing to fruition the plan of the Society. This will finance the program under the administration of the Administrative Office of the Illinois Courts.

In the summer of 1960, at the annual meeting of the Illinois Judicial Conference, made up of judges of the Circuit, Superior, Appellate, and Supreme Courts of Illinois, a representative of the Illinois State Medical Society was invited to speak on behalf of a formal program for Impartial Medical Testimony. This meeting was held at the Northwestern University Law School. Opposition to the program was expressed by several members of the legal profession; however, the conference approved in essence the program proposed by the ISMS and also recommended that monies concerned with administering the program of IMT might be part of a plan for the entire state of Illinois rather than being restricted to Cook County. The plan was presented before the Illinois Supreme Court and the judge assigned, Chief Justice Walter V. Schaefer, was favorably inclined to its inception provided adequate funding was available.

Dr. Bennett Sparkplugs Program

A decision the last week of November, 1960, by the Judicial Conference in Chicago, was to review the entire program again and see if, after initial application in Cook County, it should be extended over the entire state. The outcome of the review was the conclusion that an experimental program should be inaugurated. A

sparkplug for the adoption of the system was Dr. Richard Bennett first IMT Committee Chairman, who worked long and hard at getting the program underway. According to a report by Dr. Samuel Levinson at the December, 1960, ISMS Board of Trustees, when the program was reviewed, the ISMS had originated the idea of IMT for the state courts and had given strong backing to the activities inherent in setting a program of this nature in motion. Dr. Clinton Compere, in 1964, succeeded Dr. Levinson as chairman of the committee and has seen the program through to its present success and adoption on a permanent basis.

Supreme Court Adopts Rule 17-2

On Sept. 5, 1961, the Illinois Supreme Court adopted Rule 17-2 which put into effect a system of Impartial Medical Testimony in the trial courts of the state. The rule, patterned after rules applied or adopted in other areas, particularly New York City, provided that when an issue is raised as to the mental or physical condition of a litigant in a personal injury lawsuit and when the use of impartial testimony will materially aid in a just determination, the judge, on his own motion or that of any party to the suit may order an examination.

When the formal program, on an experimental basis, was inaugurated in 1961, for a two-year trial, examiners were to be paid from a special fund of which the Illinois State Bar Association was custodian and disbursing agent. The Illinois State Medical Society undertook to finance the payment of fees and certain administrative costs for the trial period and appropriated the sum of \$5,000 outright and guaranteed an additional \$5,000 if such became necessary. Inasmuch as the Supreme Court felt that \$40,000 would be needed during the

period, ISMS contacted various Funds and Foundations for assistance. The Ford Foundation graciously agreed to advance \$3 for every \$2 obtained from other sources. The John Deere Foundation contributed \$1,000, the Wieboldt Foundation of Chicago, \$8,000, the Woods Charitable Trust \$1,000, and the Lilly Endowment, Inc. Fund, \$10,000.

Rule 17-2 Stated

Adoption of Illinois Supreme Court Rule 17-2 solidified the program begun in the federal court shortly before. The rule stated, "When, in the discretion of a trial court, it appears that an impartial medical examination will materially aid in the just determination of a personal injury case, the court, a reasonable time in advance of the trial, may on its own motion or that of any party, order a physical or mental examination of the party whose mental or physical condition is in issue. The examination shall be made without cost to the parties, by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society. The court administrator and deputy court administrator are charged with the administration of this rule."

"A copy of the report of examination shall be given to the court and to the attorneys for the parties. Should the court at any time during the trial find that compelling considerations make it advisable to have an examination and a report at that time, the court may, at its discretion, so order. Either party or the court may call the examining physician or physicians to testify, also without cost to the parties. Any physician so called shall be subject to cross-examination. The court shall determine the compensation of the physician or physicians."

Limitation of Rule Lifted

In the new Supreme Court Rules which became effective Jan. 1, 1967, the use of IMT examiners is authorized by Rule 215 (d) (1). One substantial change has been made in the Rule in order to allow the use of IMT examiners in any proper case. The Rule was formerly limited to personal injury actions. The new Rule states: "(1) A reasonable time in advance of the trial, the court may on its own motion or that of any party order an impartial physical or men-

tal examination of a party whose mental or physical condition is in issue, when in the court's discretion it appears that such an examination will materially aid in the just determination of the case . . ." This eliminated the initial clause of former Rule 17-2 referring to a personal injury case.

In personal injury cases there are two main issues, liability and damages. When the issue of liability is to be determined, judges and juries generally are capable of arriving at a determination. However, in deciding the existence and extent of injuries they must have expert information before coming to a knowledgeable decision. Their job is to award to the plaintiff an amount of money to compensate for the loss of earnings, cost of medical care, and pain and suffering, as the findings warrant. Diagnosis and prognosis are required, thus the testimony of doctors becomes essential.

Impartial Expert Reviews Evidence

Generally witnesses are called by each party in the litigation to support or refute evidence. These people state their positions with regard to the case and it devolves upon the tribunal to pass judgment on the evidence presented. When medical witnesses testify in opposition to each other, judges and juries are possibly confused or misled. They must choose between conflicting views in an area where they have little primary knowledge and adjudicate controversial claims.

Impartial Medical Testimony is a means of ensuring fair, equitable settlements primarily in cases involving personal injuries. By having an impartial expert review all the pertinent medical records and claimed injuries and make a report of his findings, both in writing and as a witness in court if necessary, the judge and the jury have the advantage of not having to make judgmental decisions without reports in areas which fall strictly within the purview of the medical profession. And this also allows for settlements between conflicting reports given by witnesses called by either the plaintiff or the defense. The judge has the opportunity of ordering an impartial review of the case, or either counsel may request it. Upon completion of the physician's report, a person expert in a particular medical specialty, both sides are better informed as to the verisimilitudes of the case and have additional bases for pre-trial dis-

cussion. While the judge, and/or a jury, are not bound by any of the medical findings, these are an aid in coming to a just solution.

Procedures Followed in IMT Cases

1. Judge invokes Rule 215 (d) (1)
2. Judge contacts supreme court administrator requesting IMT examiner
3. Court administrator contacts Illinois State Medical Society for IMT examiner
4. ISMS selects an IMT examiner from the panel of the medical speciality relating to the injury involved
5. ISMS relates the identity of the IMT examiner to the court administrator
6. Court administrator schedules the examination of the plaintiff, and obtains pertinent medical records for the examiner
7. IMT physician examines plaintiff and prepares medical report, which is submitted to the court and the attorneys involved
8. IMT examiner is available for court testimony, as required
9. IMT examiner submits bill to the Administrative Office of the Illinois Courts

Thus it is that there is a need for a volunteer panel of expert physicians, specialists each in various fields of medicine. This panel provides the backbone of the system. Without it there would be no impartial medical program and no testimony given without financial interest in the outcome of the pending litigation.

The panel consists of some 400 physicians who are grouped into 20 medical specialties. These IMT examiners are selected from approximately 4,000 nominated physicians. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois. Examiners are selected from the panel in rotating sequence.

After conducting an examination the panel physician is to submit his bill to the court for approval and the State Bar Association will release the funds. This holds true also for time needed in testimony. In this manner there is no partiality to either party; no payment, not even shared court costs, would be from either litigant.

Pre-trial Agreements

In addition, it is noted that there is considerable congestion in the court calendar. By utilizing the services of the impartial panel members it may often occur that one or the other of the litigants may come to agreement with the opposition and agree to a settlement at the pre-trial stage. This will mitigate the burden of lengthy trials.

During the first three months of operation in the Illinois Circuit Court only three cases were ordered for review by an impartial medical expert. Initial progress and acceptance was slow. Only eight cases used the program in 1962, 13 in 1963, and 17 in 1964. However, in 1965 the referrals increased to 26 and dramatically increased to 59 in 1966. By the end of 1967 it is expected that over 70 cases will utilize the program (See Fig. 1.) This reflects well on the program and its acceptance as an aid in settlement of cases where medical testimony is in issue.

More Judges Using Program

As further evidence that more judges each year utilize the program, six Circuit Court judges used IMT for the first time during the first six months of 1967. During previous years the experience has been six or seven new judges each year. Also, 44 judges have used IMT examiners since 1961. Of these, 31 were from Cook County. Of the 157 cases in which an IMT examination was ordered (1961 through June 30, 1967) 129 were filed in Circuit Court of Cook County. It is hoped that in the future a greater number of judges will make use of this program, as well as parties to the suits.

While the above figures reflect ever widening acceptance of the program, the disposition of the cases is also of interest. Of the 157 cases referred, 101 of the 129 completed cases, or 78 percent, were settled at pre-trial hearings, 14 cases went to jury trial, 14 cases were dismissed; 28 cases, or 8 percent of total cases, are still pending (see Fig. 2).

Judges Express Appreciation

In some cases examination by more than one expert was necessary, thus a total of 170 examinations were accomplished. The medical specialty of the panel members called upon were orthopedics in 102 cases,

nuerosurgery and neurology in 21 cases each, and in 9 other specialty categories to a lesser extent. (See Table 1.)

Several judges have expressed their appreciation for the availability of the doctors on the panel and have indicated that the program is a significant factor in the settlement of cases. The experts have rendered a great public service, and a service to both plaintiffs and defendants. As the interest of the Bar in IMT increases, so will the salutary results of the program.

The Impartial Medical Testimony Com-

mittee of the ISMS believes that the acceptance and use of the program supports the conclusion that the procedure is sound and that there is effective operation. It provides definite assistance in the adjudication of personal injury cases. The committee commends the IMT panelists for their impartiality and objectivity and for the expertise and cooperation in processing the cases in which they participate.

Operates Under Court Budget

Now that the program has become a

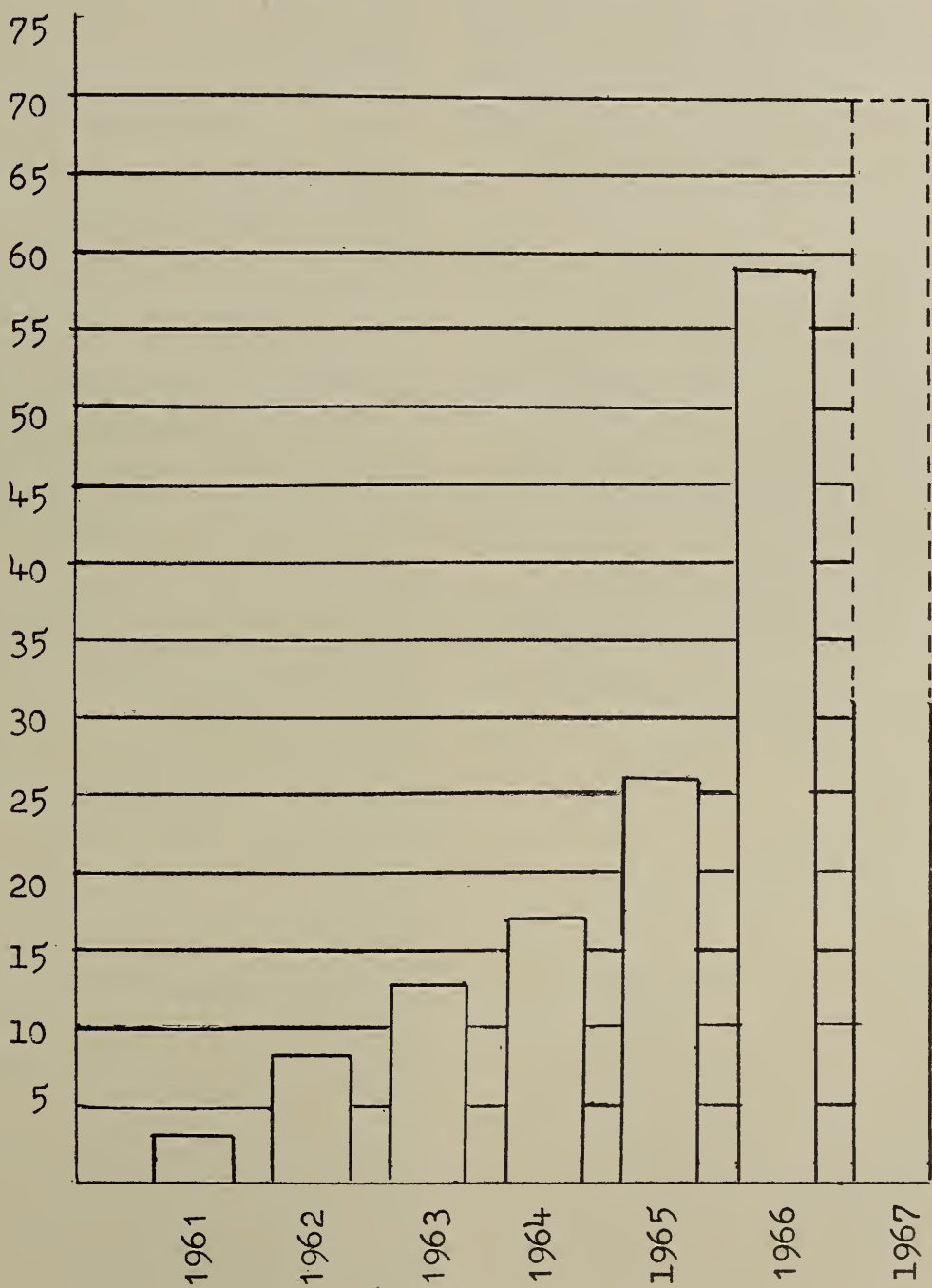


Fig. 1

permanent part of the operation of the circuit court system in Illinois, by its being included in the regular budget for court operation and by its becoming a permanent Supreme Court Rule, one may conclude that the experiment begun in 1961 has shown some significant achievement and is a success. The machinery has been established. This program, initiated in Illinois by doctors, through the Illinois State Medical Society, indicates a definite interest by the medical profession in the medico-legal field. This is of tremendous significance. It shows a concern and augers well for other legislation and governmental function in which doctors may be interested. It indicates that the Illinois State Medical Society, through its membership, is vitally concerned with the "whole man" rather than just the medical realm.

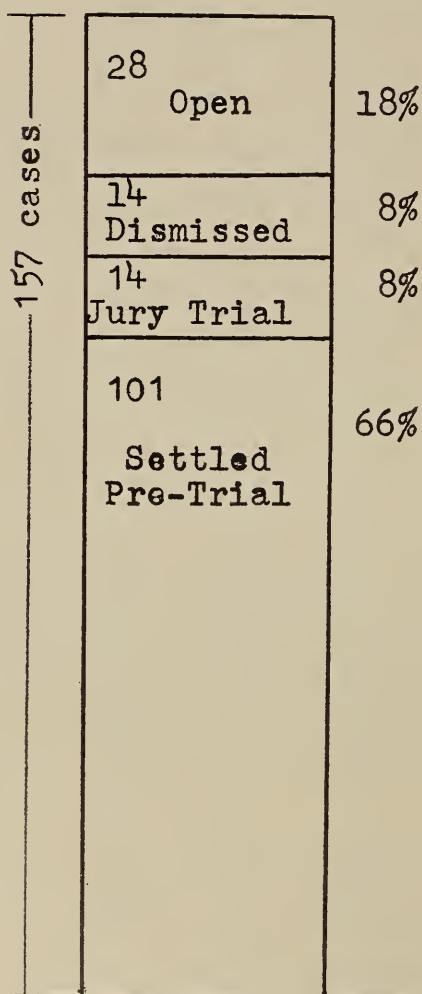


Fig. 2

Table 1.—Examinations by type of specialty area, 1961-1966

Medical Specialty	Number	Percent
Orthopedics	102	60.0
Neurosurgery	21	12.3
Neurology	21	12.3
Radiology	5	3.0
Internal Medicine	5	3.0
Psychiatry	4	2.3
Urology	3	1.7
Otolaryngology	3	1.7
Plastic Surgery	3	1.7
Ophthalmology	1	0.6
Gynecology	1	0.6
Cardio-vascular	1	0.6
TOTAL	170*	99.8

* Several cases required examination by more than one specialty.

Illinois was a trailblazer in the field of Impartial Medical Testimony. (Other states had been experimenting with the concept, but always at the instigation of the courts and/or the legal profession.) In Illinois the wisdom and foresight of the medical profession and members of the Illinois State Medical Society brought a program into being. Illinois is distinguished in this matter by being the only state in which a Supreme Court Rule authorizes the state-wide use of Impartial Medical Testimony.

Radiation Laws for Minors

Effective May 15, 1967, the Illinois Department of Public Health has required that persons under 18 years of age shall not be occupationally exposed to ionizing radiation. Since this rule applies to many medical facilities, Dr. Franklin D. Yoder, director of the department, has urged that all registered users of x-ray equipment and radioactive material be notified. He emphasized that this rule does not stipulate that minors cannot be employed in medical facilities utilizing radiation sources, but they cannot be employed to operate the radiation equipment, handle radioactive materials or enter the environs of the radiation sources when being used.

This ruling was originally adopted by the National Council on Radiation Protection and Measurements, Report No. 32. It was then studied and approved by the Governor's Radiation Protection Advisory Committee of the State of Illinois.



THE DOCTOR'S LIBRARY

THE OFFICE ASSISTANT IN MEDICAL PRACTICE. Portia M. Frederick and Mary E. Kinn, 461 pages, Illustrated. W. B. Saunders & Company, Philadelphia & London, 1967. \$7.50.

This is the third edition of a book designed essentially as a teaching aid to be used in training medical assistants. It will be of value for physicians who wish to train their own assistants. The girl who wants to do a better job will find information covering every facet of being a medical assistant.

Included are chapters on telephone technique, appointments, handling the mail, keeping records, billing and collection procedures. In addition, there are chapters on accident and health insurance, office techniques, emergencies, housekeeping, and supplies. The reviewer suggests that many physicians may wish to take the book home and read it.

T. R. Van Dellen, M.D.

SYMPOSIUM ON SURGERY OF THE OCULAR ADNEXA. Arthur Gerard DeVoe, M.D., Howard Naquin, M.D., Byron Smith, M.D., Joseph A. C. Wadsworth, M.D., Sidney A. Fox, M.D., T. E. Sanders, M.D., Everett R. Veirs, M.D. 245 pages. The C. V. Mosby Co., St. Louis, Mo., 1966.

This book is a compilation of the lectures given at the fourteenth annual session of the New Orleans Academy of Ophthalmology, held Feb. 14-19, 1965. The authors are recognized and outstanding ophthalmologists in the various fields of their subjects. They have discussed the pathogenesis and diagnosis of each condition, with their favored treatments. Those sections are the most valuable which are the best illustrated, such as the presentation of Dr. Sidney Fox on ptosis, entropion, and ectropion. There are sections by Dr. Byron Smith on recon-

structive surgery for trauma and burns; Dr. T. E. Sanders on lacrimal gland; Dr. Everett Veirs on lacrimal drainage system; Dr. Joseph Wadsworth on lid and conjunctival tumors, plus pathology of orbital tumors, ending with Dr. Arthur DeVoe's discussion of non-surgical treatment of ocular adnexal tumors; Dr. Howard Naquin on surgical treatment of orbital tumors, orbital exenteration and conjunctival reconstruction. The end of the book includes the round-table discussions of the meeting, giving room for differences of opinion in the questions-and-answers.

This book, being a lecture symposium, obviously could not cover all surgical adnexal problems in 245 pages, but still is a valuable addition to all institutional libraries and to the library of the ophthalmologist or plastic surgeon interested in this subject; but it is still particularly interesting to the members and guests of the New Orleans Academy of Ophthalmology who attended these lectures and who would be pleased to have available the complete bound and illustrated source of the lecture-material.

Jack P. Cowen, M.D.

HANDBOOK OF OCULAR THERAPEUTICS AND PHARMACOLOGY. Philip P. Ellis, M.D. and Donn L. Smith. Second edition. 224 pages, \$9.75.

The second edition of this handbook of ocular therapeutics adds newer material on the drugs of the autonomic nervous system, and on various new antibiotics, anti-glaucomatous, and anti-inflammatory medications that had not yet appeared at the time of the publication of the first edition in 1963. This book was conceived as a quick reference for the busy practicing ophthalmologist, and as a guide in therapy for the beginning residents in ophthal-

(Continued on page 340)

Illinois State Medical Society

National Symposium on Psychedelic Drugs and Marijuana

April 10-11, 1968 Sherman House Chicago

Many of the nation's most prominent experts will participate. The program will be multidisciplinary with separate sessions on basic science, sociology, philosophy and law. Some of the many outstanding speakers participating during the two-day session will be:

Maimon Cohen, Ph.D.

Director of Cytogenetics,
State University of
New York School of Medicine

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EDITORIALS



THE SOCIETY FOR ACADEMIC ACHIEVEMENT

There is much in the news about Health Manpower shortage. The President has a commission and the AMA has a committee making intensive studies. Today for each individual physician there are 13 members on the health team. This will shortly rise to 17. As people become better informed they demand more and better health services. In the not too distant future more people will be serving in health services than in any other field with the possible exception of government service. All of which brings me to the subject of the motivation of youth, not only to enter the field of health but to achieve academic excellence and to secure a college education. It has long been known that children are motivated by a feeling of importance, love, and awards of various kinds.

There is one organization that deserves your consideration: it has been approved by the House of Delegates of the Illinois State Medical Society and the American Medical Association. It is known as the Society for Academic Achievement and aims to be the high school counterpart of Phi Beta Kappa. It does not conflict with the National Honor Society. It is purely an honor society. Its scholarship requirements for membership are higher than the National Honor Society. Former Dean Alonzo Grace, of the College of Education, University of Illinois, said: "The SAA is one

of the most significant developments in recent years; it is one of the most forward looking programs in the Nation in the area of identifying and encouraging scholarship at the secondary school level.

The Society for Academic Achievement has two programs. One is the award membership program for high scholarship achievement in academic subjects for the first seven semesters of high school work. The other is the scholarship letter program in which a letter is awarded for scholarship achievement for a single semester.

The SAA programs are spreading throughout the United States. It is now in more than a dozen states. The SAA is incorporated not for profit, is federal income tax exempt, and has no paid officers or trustees. Trustees include eight physicians. The founder is Harold Swanberg, M.D., of Illinois, a member of the Illinois State Medical Society's 50-Year Club, who has retired from the practice of radiology and now devotes full time to the promotion, at his own expense, of the Society for Academic Achievement.

Will you become a benefactor? Will you interest your Medical Society in the support of the Society for Academic Achievement in your own high schools?

NEWTON DUPUY, M.D.

Special Illinois Ses

Ophthalmology in Illinois (1818-1968)

JAMES E. LEBENSOHN, M.D., Ph. D. / CHICAGO

The idea of an Illinois State Medical Society was tentatively suggested in 1840 when medical conditions were still most deplorable. Disease was the great adversary of the pioneers, yet the population multiplied with waves of immigration. Settlers drifted in after the Revolutionary War, entered in great numbers following the War of 1812, and came in hordes when the Black Hawk War of 1832 drove the Indians west of the Mississippi. Those from New York and New England entered at Chicago, while the settlers from Pennsylvania and the South preferred the gateway of the Ohio and Wabash rivers. The inhabitants of northern and southern Illinois were separated by uninhabitable marsh lands. Ophthalmia ranked with malaria and pneumonia as the outstanding diseases. The Napoleonic conflict in Egypt diffused trachoma throughout Europe. Afflicted refugees took the southern path of migration producing a trachoma belt as they headed westward spreading the disease to both whites and Indians. Epidemic trachoma was confined to the southernmost 17 counties of Illinois, Jasper County being most affected. Epidemics of "ophthalmia" were observed from 1835 to 1855. The Illinois School for the Blind in Jacksonville opened in 1848. In 1934, at the suggestion of Dr. Harry Gradle, Gov. Horner established trachoma clinics in Jonesboro, Vienna, Herrin, Eldorado and Shawneetown, and a bus service brought patients from 95 neighboring villages. Improved hygiene, topical treatment and sulfonamides internally successfully vanquished the disease.

Dawn of Modern Ophthalmology

Ophthalmology came into bloom in the years, 1850-1865, sparked by the creative genius of Helmholtz, v. Graefe, Bowman



and Donders. Americans flocked to Bowman and Critchett in London, Arlt and Jaeger in Vienna, Desmarres and Sichel in Paris, Donders and Snellen in Utrecht and to von Graefe in Berlin. Before this awakening, ophthalmology was just incidental to general practice. The medical schools began establishing departments dealing with ophthalmology,—Rush, 1859; Northwestern, 1868. Chicago was fortunate in attracting two qualified ophthalmologists, Holmes and Hildreth, both members of the American Ophthalmological Society organized in 1864. The College of Physicians and Surgeons, now the University of Illinois Medical School, opened with John E. Harper (1851-1921) as Professor of Ophthalmology and Otology in 1882. The field of eye, ear, nose and throat was then divided in teaching and practice into eye and ear, and nose and throat, but about 1900, the profession realized that ophthalmology was a full time specialty and that otology belonged to the domain of nose and throat.

(Continued on page 324)

centennial Features

Early Obstetric Practice In Illinois

By FREDERICK H. FALLS, M.D./RIVER FOREST

PART II

1880 — 1890

About 1880 again the use of anesthesia in obstetrical cases claimed the attention of the medical profession and several papers were read and discussed before the annual meetings of the State Medical Society on this subject. Strangely enough the same divergence of opinion prevailed then as is noted now among members of the profession. They tried various drugs and combinations of drugs in an attempt to hit upon an ideal mixture which would nullify the pain of labor without interference of its orderly progress.

In 1879, Dr. David Booth of Sparta declared before the State Society that anesthesia should not be used for the following reasons: (1) it promotes vomiting; (2) changes spontaneous labor into forceps cases by promoting inertia and preventing the patient from aiding with the expulsion of the baby. He felt that the patient should be responsive to trauma during forceps delivery and said that involution was retarded by anesthesia.

In 1880, Dr. E. L. Herriott of Jacksonville also reported on the status of anesthesia in obstetrics. He wrote to 200 members of the Illinois State Medical Society, asking for a report on their individual experiences: 17 used anesthesia quite frequently when indicated; 12 reported limited use only; 3 had no reason to use it, and 2 were opposed to its use. Dr. Herriott himself advocated the use of general anesthesia "whenever the pain of labor is so severe that the patient welcomes it without fear of consequences." He felt also that pain was a stimulant and lessened the danger of anesthetics. In his experience there were no deaths from anesthesia. Ether, chloroform and ethyl bromide were used, and at that time the latter was more favored by many men. Herriott stated, "My

preference is for equal parts of chloroform, alcohol and ether, and if everything goes favorably I leave the stopper in the ether bottle." He stated further that "the time to commence anesthesia during labor is when without it the patient will unnecessarily suffer and the time to withdraw is when without it she will not suffer." The danger to the child from deep anesthesia given to the mother was brought out by discussion of his paper.

Dr. Charles Warrington Earle stated in 1885 that postpartum hemorrhage could be treated by the faradic current with excellent results. The practitioner was advised to stay by the patient's bedside for at least an hour after delivery to assure himself frequently that the uterus was contracting firmly.

Up to this time carbolic acid had been used as an antiseptic for intrauterine douche. Bichloride of mercury 1:1000 largely replaced it but there was evidence that some cases showed mercurial poisoning following its use.

Eclampsia was now beginning to be better understood, and the relationship of albuminuria to the disease was noted as an effect rather than a cause. The good rules for prenatal care which were laid down were much like ours of today.

Management of retained placenta and membranes was well described. A period of watchful waiting, often trying Credé expression, was advised, supplemented, if necessary, by gentle traction on the cord. If this failed, the sterile vaginal examination was resorted to, assisting the exit of the placenta from the uterus by helping with the fingers of the examining hand. The danger of removing a densely adherent placenta was pointed out. Procrastination in the delivery of the placenta after a few hours, even if there was no hemorrhage, was considered to be unwise because an

operation might have to be performed later in the presence of severe infection. The use of antiseptic solutions during these manipulations and the need for meticulous cleanliness in carrying them out were stressed.

Ectopic pregnancy had only recently been understood and naturally had excited particular attention. A most remarkable type of treatment was suggested and practiced by Thomas of New York. When the usual presumptive signs of pregnancy were followed by paroxysmal pelvic pain, irregular bleeding and a small tumor in the region of the tube, an ectopic pregnancy was suspected or diagnosed. The destruction of the life of the fetus was the logical answer to the problem of preventing rupture of the tube. This was thought to be best accomplished by use of the electric current in the following manner; the negative pole was introduced into the rectum and the positive pole over the gestation sac. The current was applied at different times and in different strengths until the size of the tumor diminished, pointing to death of the fetus. In advanced abdominal gestation at term, a hands-off policy was advised until lithopedon formation had occurred, unless sepsis supervened.

In 1886, Dr. W. W. Jaggard reported on the anatomical changes in the cervix and lower portion of the uterus during the course of pregnancy and labor. This was the first scientific exposition presented before the Illinois State Medical Society and marked the beginning of the influence of the German Schools on the thinking of American Obstetricians and Gynecologists. Jaggard also discussed hyperemesis gravidarum, clearly indicating the part played by neurosis. Twenty-eight uncontrollable cases were reported: 14 of these women recovered and 14 died. In 20 cases pregnancy was interrupted before the period of viability; 16 recovered and 4 died. Rectal feeding, stomach tube, gavage, farradic current per rectum and painting the pharynx with cocaine; all were used, as were "blisters" over the fourth dorsal vertebra, and chloralhydrate and bromides as sedatives. In patients with disproportion resulting in dystocia, forceps or version was tried. If they failed, craniotomy was performed.

Dr. O. B. Will was Chairman of the Committee on Obstetrics of the State Medi-

cal Society in 1889. In his Chairman's Address he discussed physiologic childbirth as follows: "It nevertheless is subject to pathological conditions which develop because of her environment, parentage, occupation, education, moral and mental atmosphere, fashion and all the other demands of the age, and has thereby been forced to suffer a departure from the standard of perfection seen in nature's usually beautiful adaptation of means to ends. Since this is so, it is necessary for practitioners of midwifery to be apprehensive in no small degree about normal childbirth and leads them to an exercise of judgment and art as a solution of this, nature's apparently corrupted problem."

Dr. Will also referred to what he termed "that colossus of modern medicine—the germ theory of disease." He insisted that organisms normally present in the generative tract were generally innocuous and that the problem in lying-in hospitals, at least, and probably elsewhere as well, was to prevent the entrance of virulent organisms. To this end he recommended scrupulous cleanliness and preparation of the patient before any vaginal examination was attempted, and that both the doctor and nurse attending an obstetrical case use the most efficacious antiseptic known, namely, the perchloride of mercury in a strength not less than 1:1000, on the hands, catheters, and the sponges used for external washing. Since he felt that disinfection of the accoucheur's hands was most important, he recommended that particular attention should be given to the fingernails and that, when they were about to be introduced into the vagina, they should be filled beneath their tips with soap scraped by them from the toilet cake at hand. He considered soap to be of great value as it was the safest lubricant available. "It is true that most women escape infection of such nature and in such a way, but many do not, and the numerous instances of death from chills and fever, malaria, inflammation of the bowels, milk fever and general debility, from which so many women are reported as dying during the puerperal period are suggestive of the ignorance and carelessness with which these well known principles of modern medicine are treated. It is a shame and a disgrace that such should be the case. It is worse than that—it is a crime! It

is now almost universally admitted that the finger should be inserted into the vagina as infrequently as possible. In fact, only frequently enough to secure the necessary knowledge of position and progress, in view of the greater probability of thereby introducing septic matter into the organ, even if the member has been rendered as innocuous as possible. This precaution is particularly valuable where the physician accoucheur has been compelled, in the multifariousness of his duties, to handle other cases of disease from which it might be barely possible to secure a degree of septic contamination."

As regards anesthesia, Dr. Will said: "It is not now considered necessary to permit a woman to suffer and become nervous and excited over the so-called 'nagging' pains of the first stage of labor anymore than those of the later and severer type. On the contrary, it is not considered a mere matter of choice, but of justice and necessity."

What seems to have been the first mention of a case of air embolism in Illinois is described thus: "A young physician of our city of the homeopathic persuasion, and possessing perhaps somewhat above the average intelligence of his 'school,' undertook to assist dilatation of the uterus in a case of confinement by the use of Barnes' dilator. The latter was introduced presumably in the proper position, and pumped full of air. In a few minutes the woman gave evidence of asphyxia, and soon expired. Upon withdrawal of the instrument it was found to have burst during the process of distention. The case was subsequently made the subject of a coroner's inquest. Upon opening the abdominal cavity, we found that the uterus contained a male fetus, apparently at full term, the placenta partially detached from the walls of the uterus, and two or three coagula of blood. Presentation normal, and all the pelvic organs free from any evidence of disease or injury, and that death was caused by the introduction of atmospheric air into the uterine sinuses." This was signed by D. W. Magee, M.D. and J. D. Furry, M.D.

That the idea of the use of prophylactic forceps was not new is attested by this statement from Dr. Will in 1889: "As to the use of the forceps in ordinary labor, my sentiments and practice, as those of the age, are reflected in the Clinical Re-

porter: 'It should be graven on the mind of every practitioner that the forceps is always permissible in the second stage of labor if the expulsive efforts of nature have from any cause ceased. When the first stage of labor has terminated, the os being fully dilated, the membranes ruptured, and no complications present, as tumors, cicatrices, etc., it should be borne in mind that any delay in the process of delivery is dangerous. If the delay is caused by inertia, impaction or exhaustion, the complication and danger are increased with each moment that the use of the forceps is neglected.' "

A sidelight on the practice of the time appears in this report of Dr. Will. It was his practice to use forceps to prevent the too rapid extrusion of the head over the perineum at the end of the second stage, and he said: "I do not believe it possible for any accoucheur to properly judge of the pressure on, and thoroughly protect, the perineum, without having it in sight. This is an essential point in the treatment for the prevention of lacerations. Whether the patient be in the lateral or dorsal position, the clothing being slightly raised on one side permits the necessary observation. The patient is rarely aware that this is done, and if she is, does not object when she knows for what purpose it is done." Thus it is seen that the old custom of delivering women under a sheet to protect their modesty was still practiced in a modified degree in Illinois as late as 1889.

Dr. J. S. Miller of Peoria in 1890 stated before the State Medical Society that before antisepsis, lying-in hospitals were regarded with disfavor, and the desirability of closing them by legislation was seriously considered. After antiseptic precautions were introduced, women were found to be much safer when delivered in lying-in hospitals than elsewhere—a dramatic event in medical history.

Hypnotism was being practiced in France in a few obstetrical cases, but no one reported similar cases from Illinois. This indicated the conservative attitude of the profession of that day towards hypnotism and it has persisted even to the present time.

Ergot used to stimulate contractions antepartum was mentioned only to be strong-

(Continued on page 350)

Ophthalmology in Illinois

(Continued from page 320)

The Early Ophthalmologists

Edward Lorenzo Holmes (1828-1900) graduated from Harvard Medical School, and after study abroad settled in Chicago in 1856. For a generation he was the leading ophthalmologist of the West. The Illinois Eye & Ear Infirmary dates from 1858 with his one-room dispensary. In 1864, the dispensary moved to a two-story building, soon occupied by Civil War soldiers suffering from eye and ear disease. From this period he received state aid, but since the 1870 state constitution limited appropriations to state-owned institutions, Illinois was substituted for Chicago in its name, and the Infirmary moved to a larger building on E. Pearson St., subsequently destroyed by the Chicago fire. It was re-established in 1872 at Adams and Peoria Sts., and remained there till 1966 when the institution was transferred to an elaborate new structure in Chicago's medical center. Rush Medical College had Holmes as its teacher of ophthalmology and otology from 1859 to 1898, and he became also president of the college in 1890. The first additions to his department were Cassius D. Wescott (1861-1946) and William H. Wilder, in 1893 and 1897 respectively. To commemorate his famous father, Rudolph Holmes, gynecologist, left a fund to the Institute of Medicine for an annual Holmes Lecture in ophthalmology.

Joseph Sullivan Hildreth (1832-1870) graduated medicine in 1856 and left immediately to study under Desmarres in Paris. In 1862, he married the daughter of the U. S. Senator from Michigan. Thanks to this connection he was able to establish an eye and ear hospital for Civil War soldiers, first in Washington and then in Chicago. In 1864, Hildreth was placed in charge of the former city hospital at Wentworth and 18th Sts., which he renamed the Desmarres Hospital. On Jan. 1, 1866, the hospital became the Cook County Hospital and Hildreth was appointed its oculist and aurist. In 1868, Hildreth was appointed lecturer in ophthalmology and otology in what has since become the Northwestern University Medical School.

Ferdinand Carl Hotz (1843-1908) came to Chicago from Heidelberg in 1869. He

was with Holmes at the Infirmary and Presbyterian Hospital and in 1898 succeeded Holmes in the chair of ophthalmology at Rush. Plastic surgery of the eye was advanced by his new procedures.

Daniel Sigismund Jacobsen (1837-1894) graduated from the University of Copenhagen, and after service in the Schleswig-Holstein War came to Chicago in 1866. He succeeded Hotz as ophthalmologist to Cook County Hospital and was the first ophthalmologist to Michael Reese Hospital, which opened in 1882.

Boerne Bettman (1856-1906), born in Cincinnati, was assistant in turn to Elkanah Williams of Cincinnati, Herman Knapp of New York and Otto Becker of Heidelberg. He settled in Chicago in 1881 and won immediate recognition, becoming oculist and aurist to Cook County Hospital and the Infirmary, and succeeded John E. Harper to the chair of ophthalmology at the College of Physicians and Surgeons, established in 1882 and now the University of Illinois Medical School. He translated Carl Koller's article on the discovery of local anesthesia for the *Chicago Medical Journal and Examiner*, and founded the Chicago Ophthalmological and Otological Society, which lasted from 1883 to 1889.

Samuel J. Jones (1836-1901) occupied the chair of ophthalmology and otology at Northwestern University from 1870 to 1897. He settled in Chicago in 1869, established eye and ear departments at St. Luke's and Mercy Hospitals, and was on the Infirmary staff from 1874 to 1882. He edited the *Chicago Medical Journal and Examiner*, the predecessor of the *Illinois Medical Journal*, from 1887-1892.

Henry Gradle (1855-1911) followed Jones in the chair of ophthalmology and otology. He graduated from the Chicago Medical College, now Northwestern University Medical School, in 1874. He left to Crerar Library a large collection of books and a fund for the yearly purchase of journals in his specialty. The library founded in 1890 by John Crerar, a railway magnate, purchased from the Newbury Library its important medical collection of 65,000 items. Originally in the Chicago loop, it is now adjacent to the Illinois Institute of Technology.

Brown Pusey (1869-1953), brother of the dermatologist, William A. Pusey, succeeded Henry Gradle to the chair of oph-

thalmology at Northwestern University which he occupied from 1908 to 1927.

Turn of the Century

As the 20th Century opened, the organization of specialized medical societies proceeded rapidly. In this ophthalmology took the lead. The Year Book of Eye, Ear, Nose and Throat, launched by Chicago publishers in 1900, was the first of the series. The Chicago Ophthalmological and Otolological Society, revived in 1893 with E. L. Holmes, president, was reorganized in 1903 as the Chicago Ophthalmological Society. Among the charter members not previously mentioned were:

Charles H. Beard (1885-1916) was born in Kentucky, and Bardstown is named after an early ancestor. In 1886, he located in Chicago and joined the staff of the Infirmary. His excellent text on Ophthalmic Surgery published in 1910 was adorned by his own lucid illustrations.

Casey Albert Wood (1856-1942) was appointed in 1904 to the chair of ophthalmology at the University of Illinois Medical School. He graduated from McGill University, where he studied under Osler, and after study abroad located in Chicago in 1882. He wrote monographs on Toxic Amblyopia, (1896), Ophthalmic Therapeutics (1909), Ophthalmic Operations (1911) and Fundus Oculi of Birds (1917). He edited the American Encyclopedia of Ophthalmology; and after service in World War I retired and translated into English the ancient classics of Dacrydeus, Grassus and Ala Ibn Isa.

After the Illinois Medical Society was organized in 1850, the first member expelled was an obdurate, advertising oculist from downstate. From 1860 a committee on ophthalmology made annual reports. In 1870, Holmes recommended silver nitrate, 2 percent, for the treatment of ophthalmia neonatorum. This was the period of the refracting optician-optometrists made their debut with New York's law legalizing optometry in 1908. Regarding the former, S. J. Jones in 1879 stated: "An optician holds the same relation to an oculist as an apothecary to a physician." After 1912, the annual meeting of the Illinois State Medical Society included a separate section on eye, ear, nose and throat. The Section on Ophthalmology of the A.M.A. was organized in 1879, and the following Illinoisans have

presided: F. C. Hotz (1887), Casey Wood (1898), Frank Allport (1901), William Wilder (1907), Cassius Wescott (1918), George Suker (1930), Harry Gradle (1939), Derrick Vail (1946) and Frank Newell (1965). The American Academy of Ophthalmology and Otology, so-named in 1903, was founded by Hal Foster of Kansas City, Mo. in 1896 in order to give all qualified specialists the opportunities of fellowship. Illinois ophthalmologists, honored by its presidency, are: J. E. Colburn (1899), Casey Wood (1906), G. F. Suker (1912), W. H. Wilder (1930), Harry Gradle (1938), F. Brawley (1940), and Derrick Vail (1951).

Trials and Triumphs

Though opportunity smiled on men of education and ideals, the charlatans and untrained also flourished. Ostentatious humbugs thrived in small towns, and in Chicago the papers carried advertisements on cut rates for cross eyes. Political interference in the professional activities of Cook County Hospital resulted in the civil service control of both attending and resident staff from 1905 to 1964, at which time appointments for both were reinstituted owing to the difficulty of obtaining candidates. The trend to better medical schools has reduced the 39 medical colleges established in Illinois to five, all approved by the A.M.A. In 1915, ten babies in Chicago became blind from ophthalmia neonatorum. This disaster led to the formation of the Illinois Society for the Prevention of Blindness, who succeeded in making prophylactic use of silver nitrate legally mandatory. The society was also instrumental in introducing visual screening of school children and special classes for the partially seeing.

Short postgraduate courses in the elements of ophthalmology and refraction were started by the Chicago Policlinic in 1895. So popular were such courses that the Chicago Eye, Ear, Nose and Throat Hospital, established by William Fisher in 1897, gave instruction to over 3,000 in its first 25 years. With the evolution of teaching standards, the 3-6 week policlinic courses for prospective specialists were discredited. The present short courses are solely designed to aid qualified men to keep abreast of recent advances.

Wilder in 1908 urged the profession to clean house. How could optometry be chal-

lenged when so many medical men were doing poor work in refraction. Edward Jackson of Denver noted that the qualifying examinations of the royal colleges in England are highly prized, and proposed certification by an American Board of Ophthalmology. The idea, adopted in 1917, proved so successful that similar boards have been created since in all the specialties. Certification is now essential for membership in the various ophthalmological societies, and in most teaching institutions and hospitals.

William Hamlin Wilder (1860-1935) was the secretary of the American Board of Ophthalmology from its inception to his death. Wilder traced his ancestry to a 1638 pioneer. He moved to Chicago in 1891. While at the Infirmary, he equipped the first laboratory in Chicago for investigation of eye pathology. He occupied the chair of ophthalmology at Rush (1907-1925) and in 1935 received the Leslie Dana Medal for his notable work.

Between the World Wars

Those who significantly influenced ophthalmology in Illinois during this period include the following:

E.V.L. Brown (1876-1953) succeeded Casey Wood to the chair of ophthalmology at the University of Illinois in 1917. Since Wood's resignation was followed by that of his staff, Brown had a free hand in reorganization of the department. Brown had taught at Rush since 1899, and his original faculty consisted of three recent Rush graduates, Hallard Beard (son of Charles H. Beard), William F. Moncreiff and Louis Bothman. After indoctrinating them in his methods, Brown launched a unique 2-year postgraduate course in which all examinations made by the juniors were meticulously rechecked by their seniors. By 1921, Francis Lane, pathologist at the Infirmary, and Harry Gradle were added to the staff. Brown was born in Morrison, Ill., studied in Vienna, and translated Salzmann's *Histology of the Human Eye* (1912) and the last edition of Fuch's textbook (1933). While at Cook County Hospital, he and Irons made an extensive study of the relation of focal infection to the eye. In 1926, when the University of Chicago developed a medical school on its campus, Brown accepted its chair of ophthalmology and brought Bothman with him, leaving Beard

at the University of Illinois as acting head of the department. At Brown's suggestion, Moncreiff was appointed acting head of the eye department at Northwestern University to replace Pusey. Harry Gradle might have been given the chair, had not Brown spoken adversely, irked by Gradle's irregular attendance at the University of Illinois. A permanent rift between the two resulted. A previous feud had followed Brown's bold attempt to transfer control of the Infirmary from the Department of Public Welfare to the University of Illinois. The ousted chiefs of service—Michael Goldenberg, Herbert Walker, Dwight C. Orcutt, E. K. Finlay, Harry Woodruff of Joliet, and M. H. Lebensohn—all of whom had civil service status, filed suit and won. When Harry Gradle was appointed Chief-of-Staff (1933-1945), he forthwith used his legal power to assign the chiefs of service to merely perfunctory duties, whereupon all resigned. The transfer of the Infirmary to the University of Illinois was effected in 1946 and in 1947 William F. Hughes, Jr. was appointed head of the combined institutions.

Sanford Robinson Gifford (1892-1944) assumed the chair of ophthalmology at Northwestern University in 1929, at which time Moncreiff moved to Rush as acting head of the eye department, a post vacated by the death of Lane who had succeeded Wilder. The intention of making Rush a postgraduate school failed to materialize and in 1941, its facilities and faculty were transferred to the University of Illinois. Gifford, the son of a prominent ophthalmologist of Omaha, was indefatigable in scientific and clinical investigation, and published a *Handbook of Ophthalmic Therapeutics* (1931). The memorial Gifford Lecture is the annual highlight of the Chicago Ophthalmological Society.

Harry S. Gradle (1883-1950) was born in Chicago, graduated Rush, and worked under Prof. Elschnig of Prague. Among his important accomplishments he initiated the Registry of Ophthalmic Pathology in 1921 with the cooperation of Major Callender, curator of the Army Medical Museum and the endorsement of the American Academy of Ophthalmology and Otolaryngology. Since then the registry plan extended to 26 fields and the entire entity, the American Registry of Pathology, is now under the supervision of the National Re-

search Council. Gradle also helped in establishing for the Academy a program of instruction courses, and its home-study course, launched in 1940. He was an organizer of the Pan-American Congress of Ophthalmology and persuaded the Kellogg Foundation to provide funds for Latin-American ophthalmologists to study in this country. He is honored by the Gradle Lecture of the Pan-American Congress of Ophthalmology, inaugurated in 1948. Jules Stein, a promising, Board-certified ophthalmologist and assistant to Gradle (1923-1925), left to form the Music Corporation of America. In 1961 he founded "Research to Prevent Blindness" which has so far engaged in five building fund projects to further eye research, given three \$25,000 awards to distinguished investigators, and established the Jules Stein Eye Institute in Los Angeles.

George Francis Suker (1869-1933) was the most devoted attending ophthalmologist at the Cook County Hospital. The annual fundus clinic which he established still maintains its popularity as the Suker Memorial Fundus Clinic. Robert Von der Heydt (1875-1946), a student of Vogt and translator of his Atlas, pioneered in the clinical use of the slitlamp, and demonstrated its value to residents.

Several downstate ophthalmologists achieved national recognition. Arthur E. Prince (1852-1928) moved the Prince Sanitarium of his father from Jacksonville to Springfield. He devised the Prince rule for measuring accommodation, the roller forceps for trachoma and the heated cone for pasteurizing corneal ulcers. Thomas Hall Shastid (1866-1947) was a versatile scholar with degrees in medicine and law. He practiced in various towns in Illinois before settling in Duluth in 1922. He held the chair of History of Medicine at the American College in St. Louis (1907-1912), authored numerous articles relating to the history of ophthalmology in the American Encyclopedia of Ophthalmology and wrote one of the first short texts on this subject. A prominent group organization is the Gailey Eye Clinic, occupying a city block in Bloomington, established by Watson Gailey (1882-1959) with a staff of 8 ophthalmologists and an approved eye residency program. Gailey was born in Ashland, Ill., served as medical officer in World War I, did cataract surgery in India in 1931, and

in 1946—at the request of the Pan-American Sanitary Bureau—studied the ocular complications of onchocerciasis in Guatemala. The Gailey Eye Foundation, which he established, publishes an excellent eye bulletin and subsidizes the preparation of teachers for the visually handicapped.

Since World War II

Ophthalmology was favored as a new career by multitudinous demobilized medical officers of World War II. To fill their needs comprehensive postgraduate courses were established at Northwestern University and the University of Illinois, and the available residencies were greatly increased. Under the influence of the American Board of Ophthalmology the length of eye residency was gradually increased to three years. The Joint Commission on Accreditation of Hospitals, formed in 1952, covered also the approval of eye residencies. Nearly all post-war residents had wives and children, and received adequate remuneration. In earlier years many were certified in both ophthalmology and otolaryngology by the respective Boards but extended requirements, making this no longer possible, sounded the knell of the combined practice of eye, ear, nose and throat. The new ophthalmologists favored elaborate, impressive equipment in contrast to the simple effective apparatus of their predecessors. The expansion of ophthalmology created a demand for paramedical ophthalmic technicians to help in the chores of lens measurement, perimetry, tonometry, tonography, orthoptics, clinical photography and contact-lens fitting; and evolved subspecialties in retinal detachments, cataracts, glaucoma, motility problems, and keratoplasty.

In 1942, when the University of Chicago decreed that all clinical departments be full time, Brown and Bothman resigned and Arlington C. Krause became head of the eye department and its only ophthalmologist. With his five residents he handled an exhaustive volume of work. After Frank Newell was appointed in 1953, as department head, Krause soon left to be chief of the ophthalmic section at the V.A. Hospital in Memphis. The approach of the Illinois Sesquicentennial signalled a shift to a younger generation as several ophthalmologists in key positions attained emeritus status:

Derrick T. Vail (1898-), son of a celebrated ophthalmologist of the same name, headed ophthalmology at the University of Cincinnati (1937-1942) when he was summoned to be the Army's senior eye consultant in the European Theater. While overseas he was offered the chair of ophthalmology at Northwestern University and assumed the post in the fall of 1945. At the same time he resumed the editorship of the *American Journal of Ophthalmology* and transferred its office to Chicago. Under his guidance the circulation zoomed from 1800 to 9500, and became the most widely read ophthalmic journal in the world. Vail also edited the *Yearbook of Ophthalmology* from 1949 to 1959, when W. F. Hughes assumed the task. During a brilliant career Vail received every distinction that ophthalmology bestows, including the presidency of the Council of the International Congress of Ophthalmology, the first American honored with this highest international office. On approaching retirement Vail transferred the editorship of the *American Journal of Ophthalmology* to Frank W. Newell (1965), and the chair of ophthalmology at Northwestern University to David Shoch (1966).

Peter Clemens Kronfeld (1899-) taught successively at the eye clinics of the University of Vienna and the University of Chicago, and then headed the eye department of Peiping Union Medical College (1933-1937). He returned to Chicago to become educational director at the Infirmary, and in 1959 succeeded Hughes in the chair of ophthalmology at the University of Illinois. He wrote extensively on glaucoma, and published *An Introduction to Ophthalmology* (1938). He leaves this year for Tucson, Arizona and has volunteered a course in comparative ophthalmology at the University of Arizona.

William Alfred Mann, Jr. (1898-), son of a distinguished ophthalmologist, taught at Northwestern University for 40 years, and for 35 years was consulting ophthalmologist at V.A. Hospital, Hines, Ill. (1933-1968) where he instituted a comprehensive supervised residency program. He also advised the U. S. Pharmacopeia on eye medication (1950-1965), and continues as Trustee of the Hadley School for the Blind, and as treasurer, associate editor and historian of the *American Journal of Ophthalmology*. After Gifford's death, he was acting head of the eye department,

and retired as professor of ophthalmology emeritus.

Tribute should be paid to notable ophthalmologists, recently deceased. Beulah Cushman (1890-1964) was associated with G. F. Suker till his death, and taught successively at the University of Illinois (1922-1934) and Northwestern University (1939-64). Her special interest in disorders of motility culminated in making this her sub-specialty and in the publication of a monograph on Strabismus (1956). She and Georgiana M. Theobald represent two of the six women so far admitted to the American Ophthalmological Society. Stefan van Wien (1907-1962) came to America in 1934 as a refugee from Hitler's regime. He served in the European Theater under Vail's jurisdiction. At his death he was chairman of the Eye Department of Mount Sinai Hospital, in charge of eye pathology at Northwestern University, and had just published a fine translation of Alfred Huber's *Eye Symptoms in Brain Tumors* (1961).

Illinois ophthalmologists have not neglected their social responsibilities. Dues of the Chicago Ophthalmological Society cover automatically membership in the Illinois Society for the Prevention of Blindness. For some years a committee of the Society cooperated with the Chicago Lighthouse in the establishment of a low-vision project. In 1961 several members launched FOCUS (Foreign Ophthalmology Consultants of U.S.) for service in Haiti, which has been in continuous operation since. Clinics have been organized at Porte de Paix and Les Cayes. More than 50 ophthalmologists from Illinois and elsewhere have participated. Many of the founders, including James McDonald, Arthur Light, Thomas Stamm and J. Robert Fitzgerald, Professor of Ophthalmology at Loyola Medical School, have evinced their dedication by six or more trips.

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“Breathing’s a snap again,” he said gingerly.

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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

Precautions: Until patient’s response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care

to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

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SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Workshop Helps MD's Snip "Red Tape"

More than 125 physicians and medical assistants got expert coaching on preparation of IDPA, Medicare and other government forms at an ISMS workshop Feb. 15 in Belleville. This first Workshop on Government Health Programs grew out of a pressing need for doctors to learn the intricacies of these programs, determine eligibility, accurately complete forms and be assured of prompt, correct payment. Dr. Matthew B. Eisele presided; Dr. William Knaus, president of the St. Clair County Medical Society, extended a welcome. The program was sponsored by the ISMS Committee on Public Relations.

* * *

On-The-Scene ISMS Study Proposed in Nurse Disputes

An official ISMS representative would make an on-the-scene study in disputes between nursing staffs and hospitals, under a plan recommended to the Board of Trustees by the Advisory Committee to Paramedical Groups. Calling attention to the "increasing disputes" over working conditions and salaries, the request from the Sub-Committee on Nursing said, "It would be beneficial to have the Board appoint an official ISMS representative to be on the scene for the purpose of evaluating the problem and reporting back to the society." Appointment of such observers would be limited to a member of the ISMS Nursing Committee or the ISMS trustee in the district involved, (the trustee in the adjoining district if a conflict of interest exists).

* * *

Thousands Expected to Enroll In ISMS Malpractice Plan

An enrollment of 4,000 to 5,000 doctors in the ISMS-sponsored malpractice insurance program is expected within five years. The estimate was made by Employers' Group of Insurance Companies, underwriter of the program, which said this enrollment figure is essential to the plan's success. Parker, Aleshire & Co. will administer the program, which is intended to assure standard coverage at equitable rates; spare doctors from arbitrary cancellations, and create a proper legal climate.

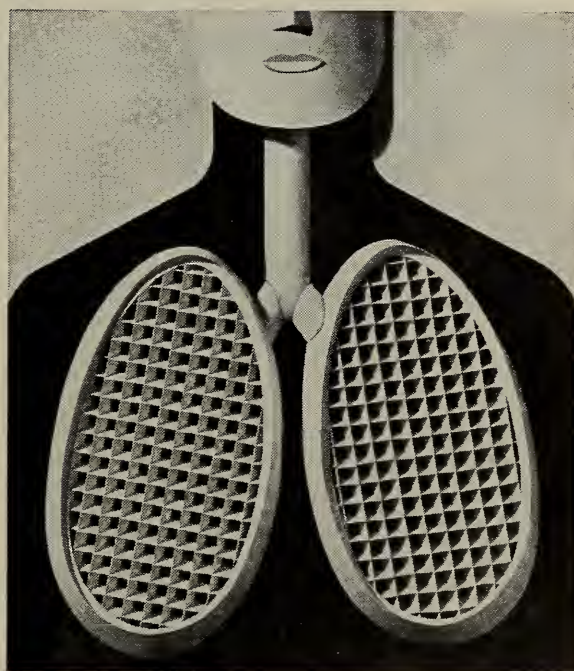
* * *

Almost Two Million More Get Disaster Self-Help Diplomas

An additional 1,894,183 Americans were graduated last year from medical self-help classes. The training enables them to take care of the injured and sick in a disaster when no doctor is present. All told, 4,773,844 people have been trained in the program, developed by the Office of Civil Defense and the Public Health Service with the blessing of the AMA and ISMS.

—Don Freeman

The ventilator pill



Dainite[®]KI, bronchodilator/expectorant

Each tablet contains: Aminophylline 3.00 gr, Phenobarbital 0.25 gr, (WARNING: May be habit forming), Ephedrine HCl 0.25 gr, Potassium iodide 5.00 gr, Dried Aluminum Hydroxide Gel 2.50 gr, Benzocaine 0.25 gr.

Tell your bronchial asthma, pulmonary emphysema and chronic bronchitis patients to take it three times a day. In most cases, that's about all you'll have to do. Because this one does more than just open up the airways.

The Ventilator Pill reduces constriction and stimulates respiratory secretions. Helps liquefy thick mucus plugs. Makes cough more productive.

It helps reduce frequency and severity of asthma attacks, too. And, because it's systemic, you know you get action where you want it... in the system.

You might say The Ventilator Pill is a good name for DAINITE KI. Your patients will probably say the same thing.

Indications: For the treatment of mild or severe bronchial asthma, and in pulmonary emphysema, in chronic asthma, in chronic bronchitis and in those patients who consistently develop a thick, viscous, tenacious sputum and thus have difficulty in expectorating accumulated secretions from the bronchial tree

during and following an asthmatic attack. DAINITE[®] KI has been specifically formulated to provide extensive therapeutic action in the asthmatic patient. Anti-nauseant factors afford the administration of a therapeutic dose of aminophylline without the high frequency of gastric intolerance usually associated with this drug. **Contraindications:** Should not be administered to patients sensitive to aminophylline or sympathomimetic drugs and should be used with caution in patients with cardiovascular disease and hypertension. Also contraindicated in those patients who have had a severe reaction or are sensitive to or have an idiosyncrasy to potassium iodide. **Precautions:** See contraindications. In some elderly patients, barbiturates may cause excitement rather than depression. **Side Effects:** Occasionally nausea, vomiting and gastric irritation occurs. In addition, side effects attributable to potassium iodide may occur, acne, rhinorrhea, metallic taste and parotitis. Prolonged use of iodides may rarely lead to hypothyroidism. Skin rash may be observed in patients hypersensitive to barbiturates. **Dosage:** Adults—1 tablet on arising, 1 tablet at 4 P.M., and 1 or 2 tablets at bedtime.

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Looking for A Place to Practice?

Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the Journal is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

CALHOUN: Brussels; Population: 324. Estimated population of trade area, 2000. No resident Doctor for 20 yrs. Nearest Doctors at Hardin 20 miles. Nearest hospitals at Carrollton, Alton and St. Charles, Mo. 24-30 miles. 34 miles from Alton. (Population 32,550) Excellent office space and housing available. Financial assistance available. Predominant nationality: German. Excellent drug store at nearby Hardin. Agricultural area. Catholic, Lutheran & Methodist churches. Grade & high schools. Good fishing and hunting. For further information contact John Bopp, Brussels 62013 or Dr. Robert Anschuetz, 1st National Bank Bldg., Alton.

CALHOUN COUNTY: Kampsville; population: 500. Trade area: 3000. No resident physician. Only 2 in county. Nearest hospital at Carrollton, 11 miles: 40 beds. 35 miles to hospital at Pittsfield. Churches: Catholic, Lutheran, Baptist & Presbyterian. Grade & high schools. Good boating and fishing in area. Agricultural community. Many fruit orchards. New water system. Contact:

Mr. Paul Campbell, Kampsville
Mr. Ansell Becker, Kampsville
Mr. N. L. Gotway, Kampsville.

CARROLL COUNTY: Lanark; population: 1500. Trade area: 3000. Two phy-

sicians until recently. Town now without a physician; (last one died recently). Nearest hospitals at Savanna & Freeport, 18 & 23 miles. 50 miles from Rockford. Local prescription drug store. Sources of income: agriculture & manufacturing; new plant will soon employ 400. 5 protestant churches. Grade and high schools. 10 miles to college at Mt. Carroll. Active Lions Club, Masonic Lodge and Legion. Local country club with golf course. Private & public golf clubs at Freeport. (36 holes.) Excellent available office space; parking lot on side; apartment above office; Contact William Shearer, Lanark.

CHAMPAIGN COUNTY: Champaign. Opening for solo practice or expense sharing arrangement in new medical office bldg. in Champaign across street from Burnham City Hospital. Only 10 active G. Ps. for population of 80,000. Sources of income: U. of Illinois, industry and agriculture. 2 country clubs, 5 golf courses, 2 swim clubs and other recreational facilities. For detailed information write to Dr. Richard C. Adams, 501 W. Church St., Champaign. Phone: Fleetwood 2-1928, or 359-3971.

CHAMPAIGN COUNTY: Mahomet. Population: 1500 in corporate limits; as many outside immediate corporate limits. 18 subdivisions. 10,000 population expected by 1980. Lake of the Woods, 540 acres of picnicking and recreation area—main drawing card. Nearest Doctors at Champaign, 11 miles. Largely protestant. 50% of residents employed at U. of Illinois. Good agricultural area. 4 churches. Grade, Jr. high and high schools. 1 Doctor comes 3 afternoons a week; urgent need for a full time man in addition. Contact for details—Mr. Dale Wilner, Mahomet. Phone 586-4780.

The following towns in Christian County are also reported to be in need of additional general practioners:

Edinburg, Stonington, Mt. Auburn and Taylorville. For detailed information contact: Howard P. Joslyn, M. D., Secretary, Christian County Medical Society, Taylorville.

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Our Farm Management team converted a dairy farm to a hog-and-corn operation—and beefed up the owner's profits.

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MEETING MEMOS

Mar. 20-21—"Current Management of Renal Disease" is the topic for a postgraduate continuation course at the Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland. Registration fee \$40.

Mar. 27-28—A continuation course of the Cleveland Clinic Education Foundation, 2020 E. 93rd St., Cleveland, co-sponsored by the Cleveland Dental Society,

will cover "Medical Progress and its Relationship to Dentistry." Four guest speakers along with a faculty of 20 will present 21 topics. Registration for the course is \$25.

Mar. 29-30—The 21st National Conference on Rural Health will be held at the Olympic Hotel, Seattle, Wash. Theme of the meeting is "Meeting Health Needs in
(Continued on page 342)

A Suicide Prevention Center (Continued from page 310)

TABLE IX

Disposition of 1966 Telephone Contacts

	JAN.	FEB.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEPT.	OCT.	NOV.	DEC.	TTL.
1. No referral	1	0	0	1	0	6	9	12	12	15	12	15	83
2. Referred to other source	4	8	2	4	8	6	9	28	29	48	61	29	236
3. Accepted for Clinic service	4	3	1	2	4	5	13	5	17	32	36	24	146
4. Referred back to therapist	1	0	0	1	12	1	4	16	19	19	23	13	109
5. Pt. rejected all referrals or suggestions.	0	1	0	0	0	0	4	3	6	7	19	9	49
6. Pt. hung up.	0	0	0	0	0	2	1	5	8	13	28	10	67
7. Acceptable referral for CFH if pt. calls or (i.e. when family, friend, etc. makes call to CFH)	2	2	2	2	1	1	3	4	7	17	16	7	
8. Need met at time of call but pt. urged to call again if need arises.	0	0	1	0	1	4	5	6	15	21	36	46	135
9. Pt. referred to family or some physician.	0	0	0	1	0	0	1	3	2	5	8	3	23
10. Pt. in need of therapy & can afford private therapist & referral of same given.	1	1	0	1	2	2	0	2	2	4	1	1	17
11. To call back for proper referral.	0	0	0	0	0	1	1	0	6	1	10	15	34
12. Police notified.	0	1	0	2	0	2	0	2	1	1	3	6	18
13. Pt. hospitalized	0	0	0	0	0	0	0	2	1	1	2	3	9
14. Emergency Rx recommended	0	1	0	1	0	1	1	0	4	0	2	1	11
15. Therapist contacted by CFH Clinic.	0	0	0	0	0	0	0	0	4	0	0	1	5
Totals	13	17	6	15	28	31	51	88	133	184	257	183	1,006

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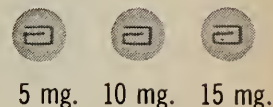


The Product

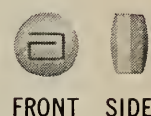
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elevation*

*For patients who can't
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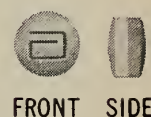
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Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



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*Please see Brief Summary
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Brief Summary

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DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
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Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

The Doctor's Library

(Continued from page 317)

mology, also for the non-specialist who are treating ocular disorders.

The handbook is divided into two sections: the first on therapeutics is designed to present some basic considerations of treatment, handling in order therapy of the various ocular tissues, then disease entities, like glaucoma, neuritis, and uveitis; the second section on pharmacology deals with the commoner drugs, alphabetically listed, with commercial names, doses, usages, preparations, side-reactions, and contraindications. A pediatric dosage table for drugs used in the ophthalmic disorders of children is appended. Because of this method of presentation, there is some overlapping of material. The extensive dosage tables for parenteral, subconjunctival, intracameral and intravenous administration are valuable.

The first edition of this book was so well received that the present second edition should find a welcome spot in libraries, institutional and private, where reference is always needed for the ever-growing number of drugs, and their newer uses.

Jack P. Cowen, M.D.

SYNOPSIS OF PEDIATRICS. James G. Hughes.

C. V. Mosby Company, May, 1967.

The need for a concise, easy to read synopsis in any field of medicine is important. It helps the practitioner review the old and get a taste of the new. It also helps the medical student to both review and to get the hard core, key material.

Dr. Hughes and his associates in this second edition of "Synopsis of Pediatrics" accomplish the above with great skill. The book reads rapidly and easily. It covers in a short space (one-third the length of a standard text) the ever enlarging field of pediatrics. One device frequently used throughout the text as a teaching aid is the clinical chart, which correlates a great deal of information in a short space.

The content of the book is a complete and informative text, going from inborn errors of metabolism to a detailed account of the physical examination of a neonate.

Although many of pediatrics more obscure entities are either deleted or only briefly described, the authors have taken the meat out of pediatrics and served it to us in a most delightful dish.

Fred Burg, M.D.

Clinics for Crippled Children

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 3, Rock Island Cerebral Palsy—Foundation for Crippled Children & Adults
3808 Eighth Ave.

April 3, Metropolis—Massac Memorial Hospital

April 3, Alton Rheumatic Fever—Alton Memorial Hospital

April 3, Hinsdale—Hinsdale Sanitarium

April 4, Flora—Clay County Hospital

April 4, Springfield General—St. John's Hospital

April 4, Lake County Cardiac—Victory Memorial Hospital

April 4, Cairo—Public Health Building

April 9, East St. Louis—Christian Welfare Hospital

April 9, Quincy—Blessing Hospital

April 9, Peoria General—Children's Hospital

April 10, Champaign-Urbana—McKinley Hospital

April 11, Macomb—McDonough District Hospital

April 12, Chicago Heights Cardiac—St. James Hospital

April 12, Evanston—St. Francis Hospital

April 16, Belleville—St. Elizabeth's Hospital

April 17, Chicago Heights General—St. James Hospital

April 18, Bloomington—St. Joseph's Hospital

April 18, Rockford—Rockford Memorial Hospital

April 18, Elmhurst Cardiac—Memorial Hospital of DuPage County

April 23, East St. Louis—Christian Welfare Hospital

April 23, Peoria General—Children's Hospital

April 24, Springfield Cerebral Palsy (P.M.)—Diocesan Center

April 24, Aurora—Copley Memorial Hospital

April 24, Mt. Vernon—Good Samaritan Hospital

April 25, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

April 26, Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Ruptured Splenic Artery Aneurysm

(Continued from page 293)

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MEDICAL MALPRACTICE LIABILITY

The 1967 Session of the Illinois Legislature removed all monetary limits insofar as wrongful death is concerned, which means that the recovery for a death claim, if caused by a wrongful act or negligence may be in any amount without limit. The provisions of this Act apply to every category of wrongful death, including medical malpractice.

The statutory limit on wrongful death has been going up over the years with a limit of \$30,000 prior to the change by the 1967 Legislature.

The above means that the risk in medical malpractice becomes greater for there is now no limit to the amount which may be recovered if wrongful death can be proven against the physician or anyone working for him. The potential liability can become rather alarming if we consider the case of a young man with a relatively long life expectancy who was making a substantial salary at the time of his death.

It now becomes imperative that every physician in Illinois review his medical malpractice insurance, for a limit of \$30,000 is no longer adequate and should be materially increased. The insurance company is only liable for the limit of the policy and any recovery over and above this amount would have to be paid by the physician against whom the judgment was obtained.

Meeting Memos

(Continued from page 334)

the '60s and '70s." It will cover comprehensive health care planning, community and emergency medical services, ways to meet health needs—such as the use of helicopters and home health services, health manpower—planning and utilization, and special problems of accident prevention in rural areas. There will be a series of six discussion groups with interesting speakers.

Apr. 8-11—An International Symposium on "Defining the Laboratory Animal in the Search for Health," will be held at the National Academy of Sciences, National Research Council, 2101 Constitution Avenue, Washington, D.C. It is the fourth

(Continued on page 360)

Professional Life's NEW! PARTICIPATING WHOLE LIFE INSURANCE

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		Accumulated Cash Value	Accumulated Dividends*
24	\$12.90	\$261.59	\$ 63.53
25	13.30	269.31	65.79
26	13.75	277.16	68.98
27	14.20	285.14	72.27
28	14.65	293.24	75.78
36	19.45	361.30	107.90
37	20.20	370.12	112.51
38	21.00	378.99	117.07
39	21.80	387.92	121.77
40	22.65	396.90	126.55
41	23.60	405.91	131.45
42	24.55	424.02	141.43
54	40.95	516.77	222.19
55	42.90	524.54	230.31
56	44.95	532.38	238.53
57	47.10	540.25	246.76

*Dividend illustrations included above are based on present scale and are neither guarantees nor estimates for future years.

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The anticostive hematinic is
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Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate).....	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron).....	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C.....	200 mg
Niacinamide.....	30 mg
Folic Acid.....	0.05 mg
Pantothenic Acid.....	15 mg

Bottles of 60



anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)



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Pearl River, New York 10965

490-7-6064

Early Obstetric Practice

(Continued from page 323)

ly condemned. Views have not changed in this respect.

While there were no institutions which could be called lying-in hospitals in the state at that time, there were men who knew what should be done to remedy the difficulties and who pointed them out clearly. The fruits of their early efforts were already beginning to be discerned by the end of the century in the form of better educational facilities, better hospitals, and a better understanding of the problems by the nursing profession and the laity.

Stimulated by a common interest, these pioneer physicians banded together to form the first gynecological society in Illinois. By their joint efforts much wheat, as it were, already separated from the chaff, was moving westward from its origin in England, Germany and France and from the large eastern centers of medical education in this country. It was greatly to their credit that in practically every instance, they evaluated new ideas correctly and passed on by their endorsement only those which have proved valuable.

We are conscious of the efforts which these early men put forth to found in Illinois, schools, hospitals and postgraduate facilities which have compared favorably with the best in the United States. It is significant that they did this on their own time without direct financial remuneration, often contributing money as well as effort to the establishment of what they felt was good for the community and for medicine. We honor and thank them for their accomplishments, and in the words of the immortal Lincoln, "dedicate ourselves to the great unfinished task which they who struggled here have thus far so nobly advanced."

Reference

History of Medical Practice in Illinois Vol. II. 1850-1900. Davis, Chapt. IX, ob-Gyne, 211-239. Illinois State Medical Society, 1955.

During 1967, the Veterans Administration sent its contact representatives to servicemen in hospitals and separation points in the U. S., and even to staging areas in Viet-Nam where servicemen are assembled after completing their tours of combat duty.



Your Front Man Is A Lady

By JEAN BERSCHINSKI

Heaven knows what the doctors would do without you! A sublime compliment paid by Dr. Charles L. Hudson to the delegates of A.A.M.A.

Quite literally, physicians don't know what they would do without their competent medical assistants. Beyond the demand that these unflagging ladies diversify their talents as medical secretary, nurse, administrator, accountant, filing clerk, lab and x-ray technician, receptionist, ad infinitum, they must also be the gracious yet unyielding bulwark against those nonpatients the physician doesn't wish to see, possess the most compassionate, reassuring telephone voice; retain the utmost sangfroid in emergencies; charm the most irascible; soothe the ruffled, and assuage the frightened. The medical assistant, if properly trained is, in short, pure PR.

Yes, properly trained—in days of yore, the physician trained his own girls. Where is the physician today who has time to instruct his staff in mastering dictating machines, credit and collection procedures, purchasing and many other complexities of this day's medical offices. When also can a doctor tutor on anatomy, physiology, preparing patients for examinations, operating the E. K. G. machine, etc.

As every physician should know by now, he does not have to give this time to his medical assistant *if* she is a member of the American Association of Medical Assistants. If for no other than selfish reasons, he should encourage her to join the A. A. M. A. . . . and it would behoove him to pay her dues. Yes sir, that's right, pay her dues!

Dr. Henry Bodner of Los Angeles, a C.M.A. Advisor to the California Medical Assistants Association, wrote in "California Medicine": "The Physicians partner in the

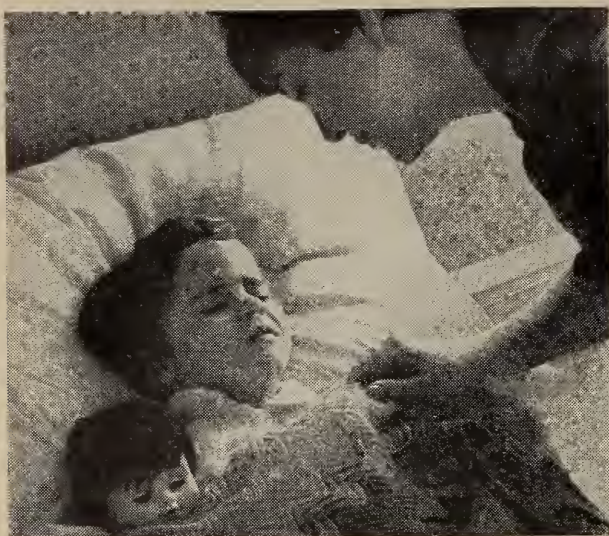
care of the sick warrants the utmost interest and cooperation by the physician. Much closer liaison between individual physicians and the medical assistants association is needed. More physicians should encourage their assistants to be members of an organization dedicated to improving themselves by constant education and training.

If there are more chinks in a physician's pedestal than one cares to break his fingernails upon, probably they are from brickbats hurled not at his service, but at the delay in getting it. Obviously, thinking patients are aware that appointments cannot be automated, but too often unthinking receptionists are imperiously officious and that familiar "Doctor will see you in a few minutes" becomes a drag. The physician who is too busy to convert his reception room girl from a field general to a smiling "receptive" receptionist who explains *why* the doctor is delayed, may discover an entire syndrome of psychosomatic disorders—freely and bitingly discussed over bridgetables, over the backyard fence and over lunchtables; by impatient, exasperated patients who are looking for a new doctor.

The Illinois Medical Assistants Association cannot guarantee transforming Miss Harm into Miss Charm, but it can open the eyes and show the way to uncorking a nepenthe for the nervous patient.

Public relations, needless to say, or is it?—is best performed on the person-to-person level, including building rapport and a tangible "pat-on-the-back" relationship with one's office aides. Your medical assistants are considerable more than office appurtenances, and the newly revised A.M.A. publication, "Winning Ways with Pa-

(Continued on page 352)



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
... adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.

Usual Children's Dose: One or two teaspoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Illinois Medical Assistants Assn.

(Continued from page 351)

tients," is an invaluable text for your secretary-administrator, and also a refresher course for the physician who thoughtlessly takes his assistant for "granite." Physicians have accepted this "bible" of front office-manship by requesting over 10,000 copies annually from the A.M.A. Program Services Department. In addition, the American Association of Medical Assistants, 510 N. Dearborn St., Chicago, 60610, has a variety of Bulletin articles and brochures to convince the physician and his medical secretary that her membership in A.A.M.A. is an asset to both. This literature covers the full cycle of reception room statesmanship: how to keep waiting patients placid and comfortable, how to be tactful and responsive on the telephone, how to schedule appointments efficiently, how to expedite correspondence, how to keep medical histories up to date, and how, the quintessence of diplomacy—to take the pain out of paying.

Physicians unaware of the objective of the association sometimes look upon it as an unionizing force to coerce higher salaries, but those who are familiar with the organization know that the members are dedicated ladies whose sole purpose is to advance their own competence and thereby serve both their physician-employers and their patients. In fact, the constitution specifically reads: "It is not nor shall ever become a trade union or collective bargaining agent." This organization is a strong ally waiting to put its collective power to work for your medical society. But too often doctors, the majority being men, look upon a "women's organization" as one which appoints committees to decide on which side of the piano the flowers should be placed. In truth, however, a dynamic force of ladies if appreciated will "tell the world" about medicine's progress, its services and the countless hours physicians give to the indigent. The programs of the Illinois Medical Assistant are strictly educational, and the rewards are translated into efficient office procedures.

If a medical assistant looks like a long-term indispensable aide, she by all means should be encouraged to join the Illinois Medical Assistants Association. And, as Dr.

(Continued on page 360)

OBITUARIES

***Dr. Sidney Ross Bazeli**, member of the board of trustees of the Chicago Medical School and holder of the school's distinguished alumnus award, died Jan. 15 at the age of 63. He was a member of the Chicago Society of Industrial Medicine and Surgery and the New York Academy of Sciences, a fellow of the American Geriatric Society, the World Medical Association and the American Heart Association. An annual lectureship will be established in his memory at The Chicago Medical School.

***Dr. Ernest H. Buch**, Kankakee, died Jan. 17 at the age of 69. He was past president of the Kankakee Chapter of The American Academy of General Practice, board member of the Kankakee county mental health center and on the staffs of St. Mary's and Riverside Hospital.

Dr. Henry Busse, a physician in Campbell Hill for 59 years, died Jan. 15 at the age of 87.

***Dr. Paul J. Cella**, Evergreen Park, died Jan. 13 at the age of 44.

***Dr. Thomas E. Conley**, Park Ridge, died Feb. 2 at the age of 77. He was the former staff president and chief of surgery at Resurrection Hospital and St. Francis Hospital in Evanston and was a member of ISMS Fifty-Year Club.

Dr. Clayton R. Curtis, Wayne City, died Jan. 4 at the age of 53.

Dr. Glen W. Doolen, Oak Park, a physician in Davenport, Ia., for 25 years, died Feb. 7 at the age of 75. He was a manager of Veterans Administration Hospitals in Memphis, Tenn. and Richmond, Va. and later was acting medical director of the University of Illinois health services in Urbana.

***Dr. Harvey D. Fehrenbacher**, Flora, a practicing physician for 48 years, died Jan. 11 at the age of 82. He was president of the medical staff of Clay County Hospital and Clay County Medical Society, and a member of the ISMS Fifty-Year Club.

***Dr. Thomas P. Foley**, a member of Oak Park Hospital's medical staff for 46 years, and a member of the medical profession for 60 years, died Jan. 4 in Chicago, at the age of 86. He served as secretary of the Medical Examining Committee of the Illinois Department of Registration and Edu-

cation, councilor-at-large, secretary and president of the Chicago Medical Society.

***Dr. Ewen J. Graham**, died Jan. 5 in the American Hospital with which he had been associated for over 30 years. He was a member of The American Academy of General Practice.

Dr. Roy I. Hardin, Chicago, died Feb. 12 at the age of 81. He was a general practitioner for 57 years.

***Dr. Martin H. Hubrig**, died Dec. 13 at the age of 78. He was a member of the Sherman and St. Joseph Hospital staffs in Elgin and was a member of ISMS Fifty-Year Club.

***Dr. Beryl A. Ingalls**, South Bend, Ind., died at the age of 75. She served as village health officer and physician for schools in Lyons and was the first woman doctor on the staff at Oak Park Hospital. She was a member of ISMS Fifty-Year Club.

***Dr. Howard P. Joslyn**, a general practitioner in Taylorville for the past 19 years, died Jan. 22 at the age of 49. He was past president and secretary of the Christian County Medical Society and was active in heart fund work.

Dr. Thomas B. Kelly, a practicing physician in Du Quoin for 44 years, died Dec. 23 at the age of 77. He was on the board of directors of Du Quoin State Bank.

***Dr. Thomas C. Laipply**, director of the laboratories and the pathology department in Chicago Wesley Memorial Hospital and professor at the Northwestern University Medical School, died Feb. 13 at the age of 57.

***Dr. Frank J. Lavieri**, Lincolnwood, died Jan. 30 at the age of 65. He was a staff member of St. Elizabeth's Hospital for 35 years.

***Dr. John B. Moore**, Benton, died Dec. 29 at the age of 42 in Franklin Hospital where he had been a surgeon. He was past president of the Franklin County Medical Society.

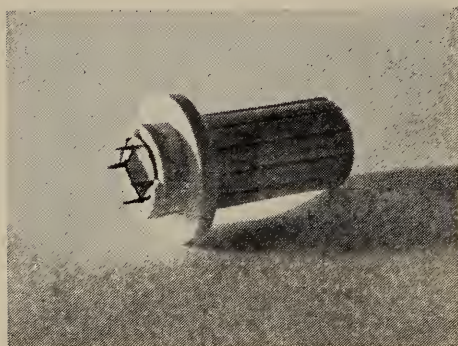
***Dr. William O'Reilly**, Winchester, died Dec. 30 at the age of 86. He was a member of ISMS Fifty-Year Club.

***Dr. Robert D. Paul**, Chicago, died Jan. 29 in Illinois Central Hospital where he had been a physician for more than 50 years.

(Continued on page 354)

To fight TB- find it first!

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with every physical examination.



TUBERCULIN, TINE TEST

(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



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- 2** BECOME AN ACTIVE FORCE FOR EQUAL EMPLOYMENT OPPORTUNITY IN YOUR COMMUNITY: Join your Local Council on Employment of the Handicapped.

For complete information write . . .
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Executive Dir.—Governor's Committee
on Employment of the Handicapped
Frank J. Jirka, M.D., Chairman
188 W. Randolph St. / Chicago, Ill. 60601
(AC 312) 372-3437

THE VIEW BOX

(Continued from page 294)

DIAGNOSIS: Intra-thoracic rib.

This is an extremely rare anomaly, only 10 cases having been previously reported. Its significance lies in recognizing it as an innocuous thoracic shadow, one not to be mistaken for other more serious lesions.

You will note a bone like density directed downward from the right superior border of the 8th dorsal vertebra and adjacent to the right heart border. Fluoroscopy revealed its posterior location within the thorax.

In the reported cases all but one had unilateral involvement. This is usually asymptomatic and revealed only by a radiograph of the chest. Resection is unnecessary. Embryologically it is felt that the defect is due to incomplete fusion between component halves of adjacent sclerotomes. This failure of fusion stimulates the formation of two lateral processes on the affected side, both of which eventually become ribs, one articulating with the transverse process and one with the vertebral body.

References

Weinstein, A. S., and Mueller, C. F. Intrathoracic Rib. *Radiology* 94: 587-590. July 1965.

Obituaries

(Continued from page 353)

***Dr. Bertram A. Richardson**, Emington, died Jan. 24 at the age of 92. He was a member of the Livingston County Medical Society, a member of ISMS Fifty-Year Club, and on the staff of St. James Hospital at Pontiac.

***Dr. Maurice J. Sherman**, Chicago, died Feb. 5 at the age of 74. He was a member of ISMS Fifty-Year Club.

***Dr. Louis A. Terman**, Glencoe, died Jan. 19 at the age of 60. He was on the staffs of Columbus Hospital and American Hospital and director of the Carmen Manor Convalescent Home.

***Dr. Edward W. Thomas**, Chicago, died Dec. 18 at the age of 69. He was a former chief of staff at St. Charles Hospital, a member of the Fox Valley Medical Society, and the American Academy of General Practice.

***Dr. Candido B. Vidal**, Waukegan, died Dec. 1 at the age of 60. He was staff physician at the Veterans Administration Hospital in Danville and Downey.

Abstracts of Board Actions

(Continued from page 254)

IDPA WARNS AGAINST RE-BILLING

Physicians not receiving immediate reimbursement from the Illinois Department of Public Aid are asked not to re-bill the department for 60 days as duplicate statements are apt to cause further delay, confusion and double payment. Questions about billing should be directed to Mr. Robert Wessell, Chief of Medical Administration, IDPA, 400 S. Spring St., Springfield 62709. The department is developing a fee profile on every physician treating public aid patients to assure that doctors are paid their usual and customary fees.

ISMS TO OBSERVE NURSE-HOSPITAL DISPUTES

The Board of Trustees has concurred with a recommendation from the Sub-Committee on Nursing that:

"In view of the increasing disputes between nursing staffs and hospitals over working conditions and salaries, it would be beneficial to have the Board appoint an official ISMS representative to be on the scene for the purpose of evaluating the problem and reporting back to the Society. Appointment of such observers should be limited to (1) a member of the ISMS Nursing Committee, or (2) the ISMS trustee in the district involved."

ALCOHOLISM COMMITTEE MADE INDEPENDENT

The Board has approved a request from the Council on Scientific Advancement that Alcoholism be made an independent committee instead of a sub-committee of Narcotics and Hazardous Substances.

CONFERENCE ON PSYCHEDELICS & MARIJUANA APRIL 10-11

The Committee on Narcotics will sponsor a conference on Psychedelic Drugs and Marijuana April 10-11 at the Sherman House, Chicago. There will be no conference registration fee for ISMS members who are urged to attend.

COMPREHENSIVE HEALTH PLANNING

The Board has approved a recommendation from the Council on Legislation that a Task Force on Comprehensive Health Planning be appointed. Purpose of the Task Force will be to keep abreast of all developments with respect to comprehensive health planning and to bring forth recommendations as to the manner in which ISMS can initiate and maintain a position of leadership. Some \$2.5 million is available in Illinois under HR 6418 passed by the 90th Congress. According to Dr. Franklin D. Yoder, Director of the Illinois Department of Public Health, Illinois has already received \$96,000 and has set up an area-wide agency in cooperation with the Chicago Medical Society and other organizations, and work in other areas of the state is under way.

(Continued on page 356)

Abstracts of Board Actions

(Continued from page 355)

PUBLIC AID PAYMENTS TO DOCTORS INCREASE 61%

Dr. Henry A. Holle, Medical Director of the Illinois Department of Public Aid, has informed the ISMS Board of Trustees that since IDPA adopted the policy of paying usual and customary fees, payments to Illinois physicians has risen 61 per cent. In 1966, IDPA paid Illinois physicians \$5,466,000; in 1967 this figure rose to \$8,796,000.

WATER AND AIR POLLUTION

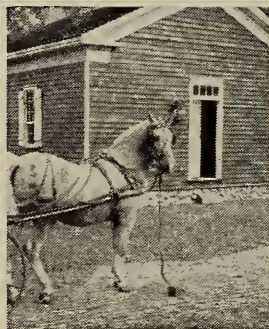
The following physicians will represent the medical profession in a water and air pollution educational program sponsored by the Illinois Department of Business and Economic Development: Newton DuPuy, Philip Thomsen, Arthur F. Goodyear, Frank J. Jirka, Edward A. Piszczek, William E. Adams, William M. Lees, Thomas P. de Graffenreid, George Giffin, Darrell Trumpe, Charles Asbury and Frank Bihss.

Illinois State Medical Society
128TH ANNUAL CONVENTION
May 19-22, 1968

Sherman House

Chicago

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*As shown by *in vitro* studies.

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



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Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093—Telephone (312) 446-8440.

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

NEW SINGLE CHEMICALS

HIPREX: Antibacterial-Urinary R
Manufacturer: Riker Laboratories

Nonproprietary Name: Methenamine Hippurate

Indications: Long term therapy of acute, chronic and recurrent urinary tract infections.

Contraindications: Renal insufficiency, severe hepatic insufficiency, severe dehydration, and as sole therapeutic agent in acute parenchymal infections causing systemic symptoms.

Dosage: Adults and children over 12 yrs.: 1 Gm., bid. Children 6-12 yrs.: 0.5-1 Gm., bid.

Supplied: Tablets-1 Gm., bottles of 100

VALISONE: Corticoid-Local R

Manufacturer: Schering Corp.

Nonproprietary Name: Betamethasone 17-valerate

Indications: Psoriasis, eczema, various dermatitis, lichen planus, lichen simplex chronicus, intertrigo, ano-genital pruritus, sunburn, miliaria.

Contraindications: Tuberculosis of the skin, viral infections with skin lesions.

Dosage: Apply topically one to three times daily.

Supplied: Cream-0.1%, tubes of 5 and 15 Gm.

PRO-TET: Biological R

Manufacturer: Lederle Laboratories

Nonproprietary Name: Tetanus Immune Globulin, Human

Indications: Passive immunization.

Contraindications: Not for i. v. inj.

Dosage: Adults-250 units i.m.

Children-4 units/Kg. i.m.

Supplied: Vials-250 units.

VASAL: Antispasmodic R

Manufacturer: S. J. Tutag & Co.

Nonproprietary Name: Papaverine HCl

Indications: Cerebral and peripheral ischemia associated with arterial spasm, myocardial ischemia complicated by arrhythmias.

Contraindications: None mentioned.

Dosage: One capsule every 12 hrs., may be increased to two caps. q12h or one cap. q8h.

Supplied: Capsules-150 mg. (sustained release)

COMBINATION PRODUCTS

NEBAIR: Bronchial Dilator R

Manufacturer: Warner-Chilcott

Composition: Isoproterenol HCl 63 mcg./metered spray

Thonzinium Bromide 95 mcg./metered spray

Indications: Acute bronchospasm in cases of moderate and markedly severe bronchial asthma, emphysema, chronic bronchitis with reversible bronchospastic components.

Contraindications: Preexisting cardiac arrhythmias associated with tachycardia; hypersensitivity to either ingredient.

Dosage: Adults and children over 12 yrs.: One or two sprays q3-4h. If two sprays are necessary they should be spaced 1 min. apart.

Not for children under 12 yrs.

(Continued on page 360)

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- CONVERSION PLAN AVAILABLE AT AGE 70
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Expenses Included**

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program with provisions for
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SPECIALTY REVIEW COURSE IN OB-GYN, May 6
 SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 13
 SPECIALTY REVIEW COURSE IN MEDICINE, PART II, June 3
 SPECIALTY REVIEW COURSE IN THORACIC SURGERY, April 1
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
 PROCTOSCOPY & VARICOSE VEINS, One Week, May 6
 ESSENTIALS OF PLASTIC SURGERY, One Week, April 1
 FLUIDS & ELECTROLYTES, One Week, April 22
 GYNECOLOGY, One Week, March 25
 OBSTETRICS, One Week, April 1
 ADVANCES IN UROLOGY, Two Days, March 28
 RADIOISOTOPES, One or Two Weeks, First Monday each month
 BASIC INTERNAL MEDICINE, One Week, April 22
 GENERAL PRACTICE REVIEW, One Week, May 6
 CLINICAL NEUROLOGY, One Week, April 29
 ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

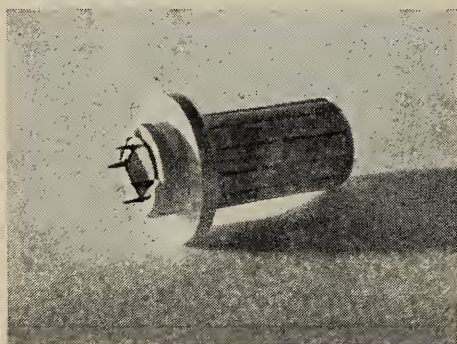
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



330-8/6135

Meeting Memos

(Continued from page 342)

symposium of this nature, the first to be held in the United States.

Apr. 10-11—The National Symposium on Psychedelic Drugs sponsored by the Illinois State Medical Society, will be held at the Sherman House, Chicago. Noted speakers and authors, authorities on drug use and control, and medical personnel will appear in an open, free discussion of the uses and misuses of drugs and marijuana. Registration forms and further information are available from ISMS headquarters.

Apr. 15-19—The Canisius College "Gas Chromatography Institute" will be held at the college in Buffalo, N.Y. This is intended as an introduction to the theory and practice of gas-liquid and gas-solid chromatography. Extensive laboratory sessions will be included. Fee: \$125 including textbook.

Apr. 16-17—Sixth Annual Meeting, American Association of Planned Parenthood Physicians, Gunter Hotel, San Antonio, Tex.

Illinois Medical Assistants Assn.

(Continued from page 352)

Rouse, the A.M.A., President, advised and many satisfied physicians know, a little subsidization of her dues and time off to join the "hierarchy" is an investment with returns compounded well beyond the annual average of the twenty dollars covering local, state and national dues.

In social statemanship, reception room receptivity, telephone gentility, laboratory logistics and the A B C's of billing and bookkeeping; a medical assistant—as a member of the Illinois Medical Assistants and ideally in pursuit of her certification—assures her doctor-employer that both he and Heaven wouldn't know what to do without her.

New Pharmaceutcial Specialties

(Continued from page 358)

Supplied: Aerosol for oral inhalation-12.6 Gm. of solution.

NORLAC: Vitamins/Minerals Comb.-Prenatal o-t-c

Manufacturer: Rowell Laboratories

Composition: Eleven vitamins and six minerals.

Indications: Nutritional supplement in pregnancy and lactation.

Contraindications: None mentioned.

Dosage: One tablet daily.

Supplied: Tablets-bottles of 100, 500 and 5,000.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 4

April, 1968

BLUE SHIELD WELCOMES YOU

Ask about Our New
USUAL & CUSTOMARY
Fee Program

Your Questions
About
MEDICARE
Answered Here

Our Services to Physicians Include:

- Branch Society Programs
- Hospital Medical Staff Meetings
- Special Communications
- Field Services
- Educational Seminars
- Medical Assistants
- New Chicago Seminars
- Assistants

1967 Medical Assistants Seminars

Blue Shield Booth at ISMS Annual Meeting

Blue Shield invites you to visit its booth in the exhibit area at the Sherman House during the Annual Meeting of the Illinois State Medical Society, May 19-22.

The booth will be staffed by representatives of our Plan qualified to answer your questions pertaining to our Blue Shield operations in general and Medicare in particular.

Literature will be available pertaining to our Usual and Customary Plan which became effective last August following approval of the State Society's House of Delegates to apply the Society's definitions of Usual, Customary, and Reasonable to new Blue Shield accounts and to make payments to physicians on that basis.

We will also have literature available pertaining to our new Blue Cross Blue Shield 65 program which will be offered soon to all new subscribers over age 65 instead of our present Series 65 Major Medical program. Non-group members will be encouraged to switch from our Major Medical program and obtain broader coverage under our Blue Shield 65 Plan which includes services covered when traveling outside the United States which Medicare, in most instances, disallows.

When Medicare became effective July 1, 1966, and Blue Shield was appointed Part B carrier for

the counties of Cook, DuPage, Kane, Lake, and Will, we broadened our communications effort to keep physicians and their office assistants informed of ongoing changes with respect to covered services, processing, and information we need to speed payments to physicians who accept assignments or to patients whose physicians bill them directly.

We have staff available to make personal calls to your office and to assist you or your office assistant in preparing our Blue Shield Physicians Service Report or assist you in other matters pertaining to our overall operation.

In visiting the exhibit area during your Annual Meeting, make it a point to stop at our Blue Shield booth and meet our representatives; let them describe our services to you; and let us know how we can serve you better.

LET US HELP

For assistance in matters pertaining to Blue Shield in general and Medicare in particular, contact one of our Special Representatives in our Professional Relations Department, MO 4-7100 extension 235, Blue Shield Plan of Illinois Medical Service, 425 North Michigan Avenue, Chicago 60601.

(This is not an advertisement)

ASK BLUE SHIELD

● ● ● ABOUT MEDICARE

Q How can I collect payment for my services after the death of my Medicare patient?

A If your patient executed an assignment before death and you agreed to accept, payment will be made to you as usual. If your patient did not execute the assignment before death, payment may be made to you provided you agree to accept the "reasonable" charge as payment in-full for your services. This can be accomplished by completing and signing the **Request for Payment Form SSA 1490**, indicating in item 12 that you accept assignment.

Q Will I be notified when payment has been made to my patient on an itemized bill?

A You will not be notified. The matter of payment is between you and your patient. If you accept an assignment, the patient is notified when payment is made to you so that he will know what balance is due.

Q Is my "code" number the same as my AMA education number?

A It is not the same. However, you may obtain the code number by contacting the Government Contracts Division of Blue Shield.

Q Many times the radiologist or pathologist is not told the nature of an illness or injury by the referring physician. Does this lack of information delay payment for their services?

A Yes, it can delay payments. The diagnosis or nature of the illness or injury should be included in the radiologist's or pathologist's report.

Q As a consultant, how should I submit my bill? With the attending physician?

A When two or more physicians render medical services during the same hospitalization, each physician should indicate on his report the condition or illness specifically treated by him.

Q When a patient is operated on by two physicians for an extensive procedure necessitating prolonged post-operative care, what is the proper method for the two physicians to claim payment?

A When more than one physician renders service to a Medicare beneficiary (i.e. surgeon, assistant surgeon, internist, etc.), it is necessary for us to know what service each physician provided. In order for us to make proper payments, we need this information from each physician whether he accepts assignment or submits an itemized statement to his patient.

The AMA on Itemized Bill

At its clinical meeting in Houston, the House of Delegates of the American Medical Association adopted a report of the Board of Trustees, with amendments, which emphasized the responsibilities of physicians and medical societies when physicians bill their Medicare patients directly.

The position taken by the AMA House is as follows:

1. "The physician must report fully and specifically in his billing the nature of the services provided so that the patient may be properly reimbursed by the Medicare carrier and should guide his patient in his application for reimbursement.
2. The physician should adhere to his usual, customary, and reasonable charges.
3. Much of the misunderstanding about direct billing may be eliminated if the physician and the patient will discuss in advance the fee, and that portion of it which will be reimbursable through Medicare and that portion which will remain the responsibility of the patient.
4. The physician should explain to the patient that Medicare is not a full-paid plan; and that the patient should anticipate paying part of the fee as clearly spelled out in the law. Physicians whose usual fees exceed those which are customary in their medical area should explain in advance to their patients the effect this will have on Medicare payments.
5. Local Medical Societies should provide review mechanisms which are made freely available to the public:
 - (1) To insure that the interests of patients are protected in dealing with Medicare carriers;
 - (2) To advise all parties as to the propriety of fees which may be charged by physicians."

Properly carried out, as carrier for Part B of Medicare in the Chicago area, we can process claims more promptly for beneficiaries whose physicians bill them directly. With complete information included on the SSA Form 1490 **Request for Payment** we can also process claims more promptly for physicians who accept assignments.

NOTICE

To help speed payments, physicians in the counties of Cook, DuPage, Kane, Lake, and Will may obtain a supply of SSA 1490 **Request for Payment** forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

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Each tablet contains: Aminophylline 3.00 gr, Phenobarbital 0.25 gr, (WARNING: May be habit forming), Ephedrine HCl 0.25 gr, Potassium iodide 5.00 gr, Dried Aluminum Hydroxide Gel 2.50 gr, Benzocaine 0.25 gr.

Tell your bronchial asthma, pulmonary emphysema and chronic bronchitis patients to take it three times a day. In most cases, that's about all you'll have to do. Because this one does more than just open up the airways.

The Ventilator Pill reduces constriction and stimulates respiratory secretions. Helps liquefy thick mucus plugs. Makes cough more productive.

It helps reduce frequency and severity of asthma attacks, too. And, because it's systemic, you know you get action where you want it... in the system.

You might say The Ventilator Pill is a good name for DAINITE KI. Your patients will probably say the same thing.

Indications: For the treatment of mild or severe bronchial asthma, and in pulmonary emphysema, in chronic asthma, in chronic bronchitis and in those patients who consistently develop a thick, viscous, tenacious sputum and thus have difficulty in expectorating accumulated secretions from the bronchial tree

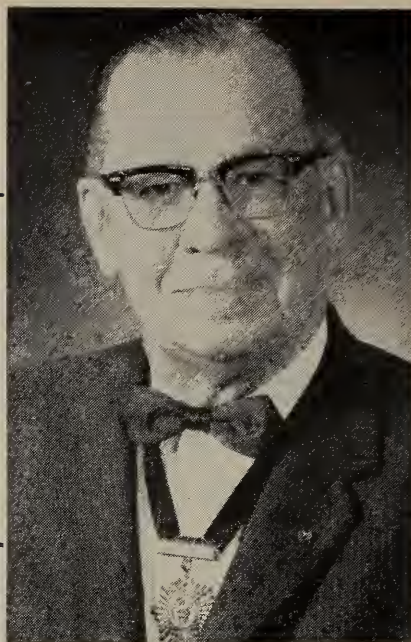
during and following an asthmatic attack. DAINITE[®] KI has been specifically formulated to provide extensive therapeutic action in the asthmatic patient. Anti-nauseant factors afford the administration of a therapeutic dose of aminophylline without the high frequency of gastric intolerance usually associated with this drug. **Contraindications:** Should not be administered to patients sensitive to aminophylline or sympathomimetic drugs and should be used with caution in patients with cardiovascular disease and hypertension. Also contraindicated in those patients who have had a severe reaction or are sensitive to or have an idiosyncrasy to potassium iodide. **Precautions:** See contraindications. In some elderly patients, barbiturates may cause excitement rather than depression. **Side Effects:** Occasionally nausea, vomiting and gastric irritation occurs. In addition, side effects attributable to potassium iodide may occur, acne, rhinorrhea, metallic taste and parotitis. Prolonged use of iodides may rarely lead to hypothyroidism. Skin rash may be observed in patients hypersensitive to barbiturates. **Dosage:** Adults—1 tablet on arising, 1 tablet at 4 P.M., and 1 or 2 tablets at bedtime.

Neisler Laboratories, Inc., Decatur, Ill.
Subsidiary of Union Carbide Corporation.

NEISLER



The president's page



Newton DuPuy, M.D.

The Illinois State Medical Society will conduct its 128th annual convention May 19-22 at the Sherman House in Chicago. I urge your attendance at this meeting where a stimulating scientific program has been planned for you and where our House of Delegates will be making decisions that may well affect all Illinois physicians.

More than 2,800 persons attended the 127th annual convention last year—nearly one out of every seven members of the society plus 104 non-member physician guests and 137 students. Twenty-two counties (out of the 96 organized county societies in the state) sent 20 per cent or more of their membership—a commendable display of interest.

Naturally, we hope the convention will attract even greater numbers this year. We guarantee it will be worth your while.

I hope you will be able to attend the President's Dinner and the Mexican Fiesta May 21 during our annual convention. I look forward to seeing you then. Details elsewhere in this issue.

Newton DuPuy, M.D.

Announcement of Coronary Drug Project

By RICHARD J. JONES, M.D. / CHICAGO

The national cooperative Coronary Drug Project, is the most comprehensive clinical trial ever undertaken of therapy for chronic noninfectious disease. Planning of this carefully designed and organized investigation was begun by the National Heart Institute in 1960. Work with patients has been in progress since last year. The principal objective is to assess efficacy of several lipid-lowering drugs in long-term treatment of men with previous myocardial infarction.

Efforts are now directed toward completing enrollment of approximately 8,400 men between the ages of 30 and 64. Enrollment of 8,400 patients is necessary because comprehensive statistical estimates indicate that number is needed in order to detect unequivocally a 25 percent reduction in five year mortality rate in a treated group. More than 2,500 patients already have been enrolled or are in the process of being accepted with the consent and cooperation of their personal physicians. Enrollment is expected to be complete by July 1, 1969, and the study ends July 1, 1974.

History of Myocardial Infarctions

The men must have a history of one or more verified myocardial infarctions to be eligible. They must be free of other major life-limiting diseases, must live within a reasonable distance of one of the study centers, and must have the consent of their personal physicians to participate. Eligible patients must also be evaluated as "I" or "II" in the functional classification of the New York Heart Association. Pa-

tients on long-term anticoagulants or drugs to lower serum lipids are ineligible, as are diabetics on insulin therapy.

The study is designed to test the hypothesis that long-term lowering of serum cholesterol in coronary-prone men may have a beneficial effect. It will assess treatment value of several drugs which have been shown to influence serum lipid levels—dextrothyroxine, chlorphenoxisobutyrate (CPIB), nicotinic acid, and estrogens. These drugs are licensed and are at present being widely promoted. It is therefore of great importance to the medical profession to get definitive information concerning their effect on life expectancy. This is not currently available. The findings from the Coronary Drug Project should give this information and may thereby result in substantial saving of life and improvement in the clinical management of coronary heart disease.

Seeking New Information

The study also seeks to collect new information on the natural history and prognosis of coronary heart disease, and acquire additional experience and knowledge about methodology of long-term collaborative clinical trials of therapy for chronic cardiovascular diseases.

A comprehensive medical evaluation is made during the initial period of baseline observation. Patients then are assigned in random double-blind fashion to one of six regimens and followed at the participating research centers for five years or until death. Close cooperative relations are

to be maintained throughout with their personal physicians.

Tabulations are being made each month at a coordinating center at the University of Maryland, Baltimore. Although it is too early to report meaningful findings from this computerized processing and analysis, significant data may be available before the end of the five years of patient follow up.

Regimens to which the patients are assigned are conjugated equine estrogens in dosage schedules of 2.5 or 5.0 mg. daily, dextrothyroxine at 6.0 mg. per day, ethyl chlorphenoxisobutyrate at 1.8 mg. per day, nicotinic acid at 3.0 gm. per day, or placebo. Drug is begun at one third the above dosage, with equal increments in dosage at one and two month intervals to attain the maximum level.

Annual Examination

Annually, a comprehensive examination, including an extensive battery of serum biochemical analyses, is done. Interval evaluations are done every four months during the follow up visits of the patient to the center. At this time, serum cholesterol level is determined, and biochemical assessment of liver function made to guard against possible drug toxicity.

The primary criterion of drug efficacy is the death rate from all causes in the drug-treated groups, compared with

that in the placebo control group. Also closely monitored are non-fatal recurrent myocardial infarctions, other cardiovascular events, and toxicity reactions.

Fifty-five centers are participating at present. In Chicago there are four participating Research Centers: Northwestern University, Presbyterian St. Luke's Hospital, St. Joseph Hospital and the University of Chicago Hospitals and Clinics, which are all actively recruiting patients for the study. Any members of the medical profession who have patients possibly eligible for the study are invited to recommend the project to these patients and have them call 744-8000, or contact one of the following principal investigators:

Dr. Olga M. Haring
Northwestern University

Dr. John S. Graettinger
Presbyterian St. Luke's Hospital

Dr. David M. Berkson
St. Joseph Hospital

Dr. Richard J. Jones
University of Chicago Hospitals and Clinics

* * *

Generic and Trade Names of Drugs:
Dextrothyroxine-Choloxyn
Chlorphenoxisobutyrate (CPIB), Atromid S.; Clofibrate
Estrogens-Premarin

Northwestern Research Spending Doubles in 5 Years to \$21 Million

The expenditure of sponsored research and training funds at Northwestern University in the 1966-67 fiscal year surpassed the \$21 million mark—almost double the figure of five years before.

Of this amount, \$17.3 million came in the form of research or training grants and contracts from federal agencies, while \$3.9 million was granted by private or State of Illinois sources.

More than two-thirds of the total amount was earmarked for research or education in the natural and physical sciences, engineering and medicine. The remainder was distributed to the social sciences and humanities, and the schools of education, law, journalism, business and speech.

In the non-federal sector, the five largest sums were received from the Ford Foundation, \$877,178; the State of Illinois, \$296,539; the Commonwealth Fund, \$137,664; the Carnegie Foundation, \$133,398, and the Dr. Kretchmer Fund, \$116,189.

The five federal agencies contributing the largest research and training grants during the 1966-67 year were the U. S. Public Health Service, \$6.9 million; the National Science Foundation, \$2 million; the U. S. Office of Education, \$1.5 million; the National Aeronautics and Space Administration, \$1.3 million, and the Advanced Research Projects Agency, \$1.3 million.

Acoustic Neuroma, Everyone's Problem

By S. BRUCE MER, M.D./ROCKFORD

In an active otolaryngologic practice, how many times a day does one hear "I'm dizzy, or I have a noise in my ear?" The odds that that one patient has an acoustic neuroma are very small, but these benign but lethal schwann cell tumors of the eighth nerve account for eight to ten per cent of all intracranial lesions. Since these tumors arise within the internal auditory meatus, one-third from the auditory division, and the rest from the vestibular division, it is our responsibility to maintain a high index of suspicion so that they are diagnosed when they are small tumors within the internal auditory canal rather than large tumors encroaching on the brain stem. As ear tumors they can be completely removed by the transtemporal bone approach of William House with maintenance of facial function and, in some, preservation of eighth nerve function.

The diagnosis of these tumors requires the team approach of the otologist, audiologist, and radiologist. All patients who have a unilateral deafness, tinnitus, or unsteadiness must be suspect. The family physician and the internist must be made aware of the early signs and symptoms so that patients who in the past were labeled as having inner ear disease, now will be screened for retrocochlear pathology. Be-

cause there is no one sign, symptom, or test that characterizes these tumors, there is no simple screening method. Many so-called "normals" will be investigated and put through elaborate, expensive procedures, but I have found that with proper understanding they are quite willing to go through the whole battery of tests.

Tinnitus, Hearing Loss, Imbalance

The most common symptoms are tinnitus, loss of hearing, and imbalance. The imbalance is usually described as a sensation of unsteadiness rather than vertigo. There is no typical balance abnormality found with these tumors. It may be manifested as episodes of true vertigo, unsteadiness dependent upon postural or positional changes or no complaints of imbalance. Nausea and vomiting are uncommon symptoms. Because of the difficulty in evaluating the various complaints of disequilibrium, we must take the challenge and attempt to determine the underlying pathology. The patient might have an abnormal taste sensation, numbness of the face, or headache. These tumors are more common in females and usually occur in the third and fourth decades.

Physical examination may demonstrate abnormalities of ninth, tenth, eleventh,



S. Bruce Mer, M. D., is Clinical Assistant, Illinois Eye and Ear Infirmary, Rockford. He received his M. D. from the University of Illinois where he specialized in Otolaryngology. He served his internship and a residency in general surgery at Cook County Hospital.

and twelfth cranial nerve function. Spontaneous nystagmus in at least one direction of gaze is found in 60 to 70 per cent of the cases. The most common form of spontaneous nystagmus beats toward the affected side (when the patient is looking toward the affected side). This is considered to be an irritative phenomenon and is an early sign. Later as the uninvolved vestibular apparatus compensates for the paralyzed side, the nystagmus beats toward the unaffected side. At times you will find nystagmus in both lateral gaze positions or directions dependent nystagmus. Spontaneous nystagmus seen when looking straight ahead usually occurs in more advanced cases.

The seventh nerve is the second most commonly involved cranial nerve. It is motor to the muscles of facial expression, sensory to the posterior superior external auditory canal and supplies taste fibers to the anterior two-thirds of the tongue and parasympathetic for secretions of the lacrimal gland, the nasal mucosa, and sublingual gland. Decreased taste and lacrimation are usually present before noticeable facial weakness. Patients with acoustic neuromas exhibit decreased sensitivity of the posterior superior portion of the external auditory canal, described as Hitselberger's sign.

Involvement of the fifth cranial nerve is usually a late sign as it indicates that the tumor has grown to a size where it is contacting the brain stem. Altered corneal sensitivity is the first sign of fifth nerve involvement.

Following the history and physical examination, a battery of routine and specialized auditory tests are given.

Patients with unilateral sensory neutral hearing loss accompanied by a disproportionate speech discrimination loss should always receive the battery of special audiologic tests.

The short increment sensitivity index (SISI) is a simplified version of the intensity difference limen test. The patient's SISI score is the percentage of 20 intensity increments which he correctly detects. Scores exceeding 60 per cent are typically yielded only by patients with end-organ lesions. The patient with retrocochlear pathology typically achieves a SISI score of zero per cent.

The vast majority of Bekesey tracings obtained fall into four basic categories. Dif-

ferentiation among the four types is based on the relationship between the tracings for an interrupted and a continuous tone. Type I where they are superimposed is technically yielded by normal persons or patients with pure conductive lesions. Type II shows the continuous tone to fall away from the interrupted tone, but the separation seldom exceeds twenty decibels. This type of tracing is typical of end-organ pathology. Type III and IV are typically yielded by patients with neural lesions. They represent pathological adaption to continuous stimulation.

Tone decay tests represent methods for evaluating auditory adaption. Threshold is established at the frequency to be tested and the tone is turned on continuously. If the patient continues to hear the tone for one minute the test is negative. If the tone fades to inaudibility in less than a minute, its intensity is increased. Tone decay is quantified in terms of the decibel difference between the threshold intensity and the intensity of the tone which was heard for one minute. Patients with end-organ disease seldom yield a tone decay exceeding twenty decibels. While retrocochlear lesions show adaption or tone decay exceeding thirty decibels.

The alternate binaural loudness balance test is a test for recruitment. The patient with an acoustic tumor usually, but not invariably shows an absence of recruitment. Positive audiometric results indicate a strong probability of a retrocochlear lesion. The smaller the tumor the more inconsistent the tests, which should emphasize the need for a complete work-up.

As these tumors usually occur in the vestibular division of the eighth nerve, it seems logical that the earliest findings should be related to the vestibular system. In several large series over 90 per cent had some type of positive vestibular findings. Methods of vestibular testing are so variable that comparison of results are difficult. There are two fundamental parameters of nystagmus: duration and intensity. The duration is a well-established criterion, but there is considerable agreement that intensity rather than duration reflects the true state of the end organ. We should not be satisfied with the crude testing of vestibular function that occurs in most of our offices, but strive for further quantification of these parameters.

The radiologic battery consists of trans-orbital and Stenver's views of the internal auditory canals, tomography and opaque cisternography. The conventional views reveal only rather gross destruction. Tomography, a fairly new development in radiology, gives us a refined method for examining the petrous pyramids and by utilizing strict indices in interpretation, very small tumors can be detected.

If the findings of tomography are borderline or equivocal, cisternography is carried out. Opaque cisternography will establish the presence and the size of the mass. The size of the mass, along with signs and symptoms, determine the system of operations that will result in the least morbidity and mortality in the patient. We can look to the future for further refinements in both our diagnostic armamentarium and our surgical methods.

History: This 26-year-old student was examined on Jan. 18, 1966. He first noted difficulty using the phone in his left ear approximately 10 months prior to examination. It was described as a sudden non-progressive loss and was not accompanied by tinnitus. The patient had episodes of unsteadiness and headaches one month prior to examination.

Examination: All cranial nerves and other neurological examinations were normal except for the fifth, seventh, and eighth cranial nerves.

Fifth Nerve: There was decreased sensation to hot and cold on the left side of his face.

Seventh Nerve: There was loss of taste on the left anterior two-thirds of tongue and diminished tearing on the left.

Eighth Nerve: Speech reception threshold and phonetic balanced words were not obtainable. Bekesy-Type III, short increment sensitivity index-unable to hear 5Db increments.

Vestibular: Electronystagmography-rotary and calorics were reported by Dr. Torok as unilateral (left) vestibular hyposensitivity.

Laboratory Data: Cerebrospinal Fluid protein-103 milligrams per one hundred milliliters. Normal range 10-40 milligrams per one hundred milliliters. X-ray plain films showed enlargement of the left internal auditory meatus. The pan-topaque cisternogram done by Dr. Valvassori delineated a 4cm x 4cm mass in the cerebellopontine angle.

Surgery: On April 1, 1967, under general anesthesia a left translabyrinthine approach to the posterior fossa was used and a large tumor of the eighth nerve resected. The seventh nerve was sacrificed because of the size of the tumor. The patient made an excellent recovery and on April 25 the sternocleidomastoid branch of the left eleventh nerve was anastomosed end to end to the distal portion of the seventh cranial nerve in the posterior triangle of the neck.

Follow-up: The patient remains well; with gross facial movements slowly returning.

AUDIOLOGIC TESTS

8th NERVE TUMORS	Pure Tone Audiogram	70% show high frequency loss air and bone conduction thresholds coincide
	Speech Audiogram	Speech discrimination levels much poorer than pure tone audiogram would indicate
	Short Increment Sensitivity Index (SISI)	Hears only 0-20% of small intensity changes
	Bekesy	Type III or IV
	Tone Decay	Rapid Fatigue
	Alternate Binaural Loudness Balance (ABLB)	No Recruitment

New Medical Communications System Being Introduced

By RICHARD A. OTT

Division of Scientific Services

The first step toward establishing a nationwide medical communications center was taken in Chicago with the introduction of a medical information storage, retrieval and transmission system. Called Telebiblios, the system can help search the world's medical literature for needed information. Photocopies of selected medical articles are then put into the requester's hands within seven minutes.

Developed by the Foundation for Medical Library Communications, a new, non-profit organization, the full operation is scheduled to begin in March, 1969. Initially the communications system will service a test group of Chicago area hospitals. Geographical coverage will be expanded as rapidly as possible.

Headquartered in Chicago

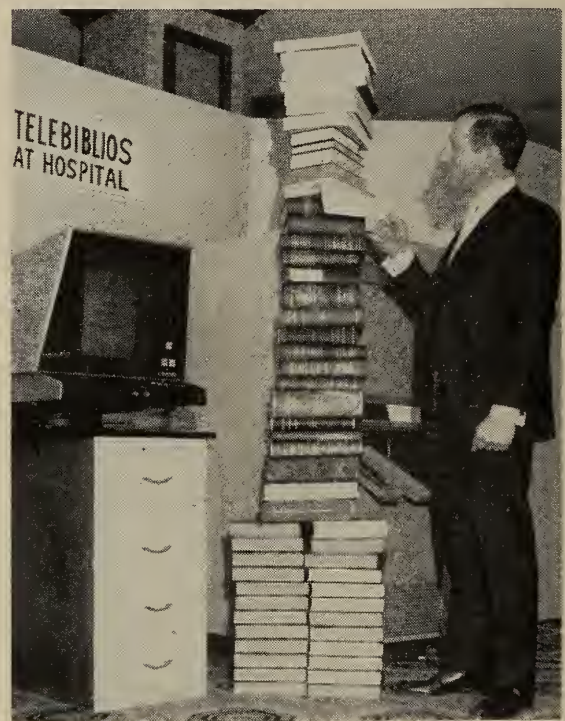
The Foundation picked Chicago as headquarters for Telebiblios because of the city's acknowledged status as one of the world's great medical centers. Chicago has five medical schools within its limits. One in every five of the nation's practicing physicians received all or part of his training in the city. And the world's greatest concentration of facilities and personnel for treatment, education and research in the health sciences is located two miles west of the loop in the 305-acre Chicago Medical Center.

In picking Chicago for its headquarters location, the Foundation is following the lead of a number of major medical associations which also recognize the city's leadership in medical training, and its geographical accessibility. Headquartered in the city today are the American Medical Association, American Dental Association, American Association of Physicians and Surgeons, American College of Surgeons,

International College of Surgeons, American Hospital Association, American Society of Clinical Pathologists, American Medical Technologists and the Association of American Medical Colleges.

Construction of 114,000 sq.-ft. Telebiblios Communications Center is underway on a 7½-acre site near Chicago's O'Hare Field. The shell of the building was completed in late 1967 and equipment is being installed as necessary funds are raised.

Need for a communications system such as Telebiblios is great. Dr. Luther Terry, former U.S. Surgeon General, has said that 150,000 lives will be lost and one million avoidable disabilities will occur this year because knowledge already at our com-



The family doctor soon will be able to "read" more than 2800 medical journals in less than seven minutes. This modern medical miracle will be made possible by Telebiblios, a new concept in medical communications.



Lawrence H. Metcoff, president of the Foundation for Medical Library Communications, demonstrates how a physician can use the Telebiblios communications system to obtain photocopies of current articles dealing with his patient's case.

mand is not being applied. The medical community is not at fault. It is physically impossible today for a practicing physician to keep up with each new advance in medicine.

Computerized Retrieval

Major sources for all information carried in the working files of Telebiblios is the United States' National Library of Medicine. Each day, the National Library indexes on computer tapes the titles of 700 new medical articles printed in this country and abroad. Soon English abstracts of foreign language articles will also be available from tapes.

Telebiblios microfilms complete articles or abstracts and stores them for rapid retrieval and transmission. Heart of the automated and simple-to-use system is a highly trained staff and a complex of carefully integrated components: computer, microfilm, cameras, and reproduction and transmission equipment.

Operation of the system, from the doctor's point of view, is simple. He calls the Telebiblios Center in Chicago from a speci-

Sponsored by the non-profit Foundation for Medical Library Communications, Telebiblios uses computers, information storage and retrieval equipment, closed circuit television and long-distance photocopying equipment to find and rush up-to-date medical literature to doctors.

ally equipped station and asks for information on a medical subject. Within 60 seconds the Telebiblios computer compiles a bibliography of article titles and transmits it to a printout machine at the local station. The doctor selects the articles he wants and six minutes later print-outs of the complete articles are in his hands.

Applications

Applications of the Telebiblios system embrace the entire medical community. Physicians, hospitals, medical schools and research scientists all can use Telebiblios to help save lives, prevent needless permanent injuries, save time and reduce the cost of medical care and research.

The doctor can use the system to check current medical thinking in the United States and abroad. Telebiblios puts at his fingertips the published knowledge of a worldwide panel of experts.

The hospital library can use the system as an extensive, centralized literature service—at a fraction of the cost of maintaining and staffing a complete facility of its own.

Telebiblios will also offer hospitals and doctors a sophisticated and increasingly important new diagnostic service—computerized biomathematics. Skilled biomathematicians will be on duty 24 hours a day at the Telebiblios Center to translate the doctor's questions into computer language and to translate computer answers into usable medical terminology, for the doctor.

The medical school can use Telebiblios to help update or replace textbook information and facilitate teaching of new developments.

Research scientists can use Telebiblios as a clearinghouse to prevent duplication of effort, a duplication that is costly in terms of wasted time and money.

The enormous computer storage and retrieval capacity of the Telebiblios system also makes possible a unique medical history service called Medifile. Medifile is a central information bureau where a person can anonymously record his medical history on a continuing basis, for use by physicians in routine or emergency situations.

The Foundation for Medical Library Communications, a non-profit organization, intends to obey all laws pertaining to copyrights. At the present time, the Foundation plans to provide photocopies of medical articles and other printed material to those requesting this information.

It is not the intent of the Foundation to deny publishers their rights. The sole ob-

jective of the Foundation is to provide meaningful information to the medical community as rapidly as possible.

This is not an experimental program. The methods employed have been applied in other activities and were demonstrated at Chicago's Water Tower Inn in Nov., 1967. And the idea to use data processing and storage and retrieval in medically oriented applications has also been broached previously; however, mechanical limitations ruled out their implementation.

Telebiblios is not set up as a medical authority. It is a service to physicians, hospitals, students, medical researchers and librarians. The service is based on data provided from the National Medical Library. This is in no way to undermine the practice of medicine, but is a strengthening arrangement. It does not alter existing doctor-patient relationships or functional operations of the hospitals or medical schools. Neither does it supercede the medical librarian. The whole intent is to expand knowledge, to save money by obviating duplicate research, and to assist the doctor as he confronts problems.

Service will be available to hospitals and practicing physicians on a subscription basis. A monthly fee will allow unlimited recall of information. The Foundation has as its goal the initiation of service in the Chicago area by January, 1969. All Illinois physicians will be informed when it is available.

VA Doubles Facilities for Treating Emphysema

The Veterans Administration doubled, during 1967, the number of medical units for the treatment of emphysema, described as "the fastest growing and most alarming disease."

VA Chief Medical Director, Dr. H. Martin Engle, reported that these special units for the management of this serious lung disease now have been set up at 52 VA hospitals and that further expansion of the treatment program is planned over the next five years as funds become available. Each of the existing units has a diagnostic laboratory.

The nationwide program of improved emphysema care is coordinated from VA Central Office by Dr. N. Stanley Lincoln. Based on 30 years experience in treatment

of pulmonary diseases, Dr. Lincoln estimates that up to 50 per cent of the adult male population of the United States is afflicted to some degree by emphysema.

He described emphysema as a disease that attacks the most vital part of the lung, the alveoli. These are small, grape-like clusters of air sacs at the end of the bronchial tubes. As inhaled air enters them, oxygen is swapped for carbon dioxide in the red blood cells flowing through the thin alveolar walls.

With the onset of emphysema, the alveoli first become dilated, then the thin walls break resulting in loss of capacity to act as gas exchangers.

Treatment of emphysema consists of slowing the persistent progress of the di-

sease and relieving its symptoms through a series of steps.

* Following the clinical diagnosis of emphysema, special laboratories confirm it through blood-gas analysis and ventilatory tests.

* Any infection of the lung, especially bronchitis, is treated vigorously with antibiotics.

* The patient must stop smoking.

* Patients are taught correct breathing to foster full use of their remaining lung capacity and to offset a natural tendency among emphysema patients to breathe incorrectly.

* Special drugs are used to widen the airways and reduce the labor of breathing.

* Mechanical assistance for breathing is administered as needed.

* Supervision by a doctor is continued after discharge through outpatient visits.

VA studies indicate that these measures, when conscientiously applied, give the emphysema patient approximately 30 per cent more useful life and reduce the need for hospitalization by 30 per cent. VA steps to combat the disease are based on a broad research program that emphasizes discovery of the causes of emphysema and developing the most effective preventive measures.

Probable causes already identified are recurrent infectious respiratory diseases such as bronchitis, asthma, allergic disorders, air pollution, vascular changes and genetic predisposition.

Smoking, which provides a specific pollution of the air in the lungs, has been clearly established as one "cause."

"Smoking," Dr. Lincoln said, "has a double edged effect on the lungs. Inhaled smoke is foreign and irritating and it slows the system for cleansing the lung." He explained that hair-like structures, called cilia, in the respiratory tract should vibrate constantly so that mucus and foreign matter (such as smoke, soot, pollen and dust) are propelled toward the mouth where it can be removed by clearing the throat. Tobacco stops this action.

Smoking at VA hospitals has been discouraged through a long-standing program that includes banning donated cigarettes for patients. Dr. Engle reemphasized the program recently with a letter that urged VA's 5,000 physicians to step up efforts to educate patients on the harmful effects of smoking.

Dr. Radner Heads Group Studying TB Clinics

David B. Radner, M.D., Chicago, has been appointed by the Illinois Association of Tuberculosis Sanitarium Boards, Springfield, to conduct a study of tuberculosis clinic and out-patient facilities in Illinois. Dr. Radner, as evaluating physician, will visit each clinic and out-patient facility in the state to determine the efficacy and extent of treatment provided for TB patients. This study is an effort to obtain uniformity of treatment and to develop minimal standards for the operation of TB clinics.

Assisting Dr. Radner in the evaluation will be Edward Kupka, M.D., of Berkeley, Cal.

The in-depth study of clinics in Illinois, the first in the state and to be one of the most extensive in the nation, is supported by a \$40,625 federal public health service grant to the Illinois Department of Public Health. The Illinois Association of Tuberculosis Sanitarium Boards has been designated as the agency responsible for the administration and conduct of the study. Ben D. Kiningham, Executive Director for the Illinois Tuberculosis Association, serves as executive secretary for the Illinois Association of Tuberculosis Sanitarium Boards.

R. G. Trummel, M.D., Macomb, President of the Illinois Association of Tuberculosis Sanitarium Boards, appointed a Clinic Co-ordinating Committee with Otto L. Bettag, M.D., Medical Director, DuPage County Tuberculosis Sanatorium Board, Glen Ellyn, as chairman. Members include: J. B. Courtwright, M.D., Watseka; R. J. Dancey, M.D., Danville; John Egdorf, Chicago; A. F. Karich, M.D., Urbana; M. R. Lichtenstein, M.D., Chicago; Earl E. Meister, Aurora; Dan Morse, M.D., Peoria; Karl H. Pfuetze, M.D., Hinsdale; W. P. Standard, M.D., Macomb; Robert H. Sykes, Chicago; Luis Ventura, M.D., Edwardsville; and Charles Williams, Carmi.

"This study should give us the guidelines and recommended standards to make it possible for us to more rapidly approach our goal of eradication of tuberculosis", said Dr. Clifton Hall, Chief, TB Control Division, Illinois Department of Public Health.

A report of the findings and recommendations will be published in the spring.

DR. BUSTILLO: A 44-year-old, female, gravida II, para II, abortion 0 was admitted to Illinois Masonic Hospital on July 20, 1966, with a complaint of chronic backache, worse within the past few months, and with a mass in her abdomen noted about 1½ months prior to admission. She was otherwise asymptomatic. Her last normal menstrual period was in May, 1966. She missed her period in June. The patient had the general appearance of normal health. The pertinent physical findings were related to the abdomen and the pelvis. The smooth, non-tender edge of the liver extended two fingers below the right costal margin. A large, firm, nodular 15x15 cm. mass present in the lower right quadrant of the abdomen was non-tender and immobile. There was no apparent free fluid. The cervix presented a severe erosion on the anterior and posterior lips. It was hard, somewhat fixed, and bled easily on contact. The Schiller test was positive throughout. The uterus was of normal size, anteflexed and also somewhat fixed. A right adnexal mass was noted to be consistent with that in the right side of the abdomen. A smaller, fixed, nodular mass was present in the left adnexal area and there was nodularity in the cul-de-sac. A Pap. smear was taken. The blood count and urinalysis were normal. The Ortho pregnancy test was negative. The alkaline

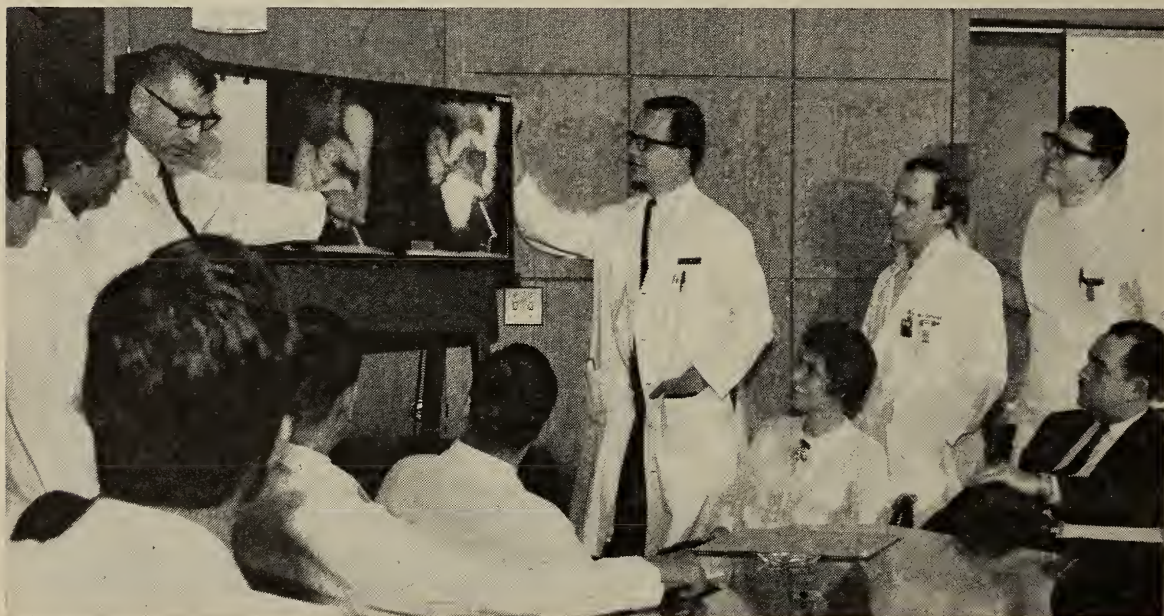
Tumor Conference

phosphatase was normal. The Pap smear was read as Class IV. A chest film, IVP and barium enema were taken. A liver scan was done.

DR. R. SCHMIDT: In order to conserve space, I have used only a few of the films. The chest film dated July, 1966, shows round areas of density scattered throughout the lung field. These have the appearance of metastatic foci. The gastro-intestinal and genito-urinary series show evidence of a mass in the pelvis which is not an intrinsic part of either the colon or the excretory system.

DR. RIVELLINI: The liver scan enables us to immediately rule out any evidence of a large space occupying lesion but it appears to me to be at least extremely suspicious of harboring a diffuse superficial metastatic seeding.

DR. BUSTILLO: On July 28, 1966, under general anesthesia, a D&C, cervical and va-



The Tumor and Isotope Committee of the Illinois Masonic Hospital presents weekly Tumor Board Conferences in the Jonas Pavilion Conference Room. Pictured are some of the participants in the conference reported here:

Orlando Bustillo, M.D., E. Goldman, M.D., Richard H. Schmidt, M.D., Giuseppe Rivellini, M.D., Jasper F. Williams, M.D., John G. Masterson, M.D. and Adele Gecht, M.D.

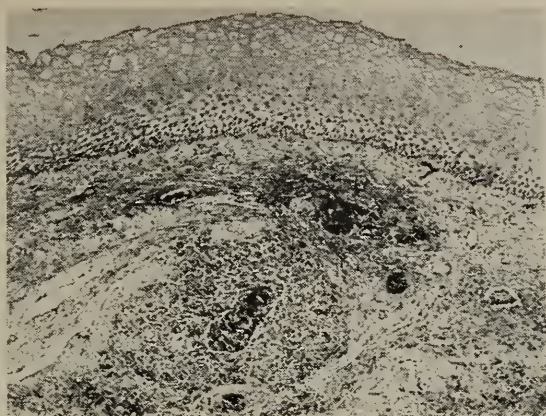


Fig. 1 Nests of anaplastic epithelial cells in stroma and vascular spaces of cervix. Note intact cervical mucosa.

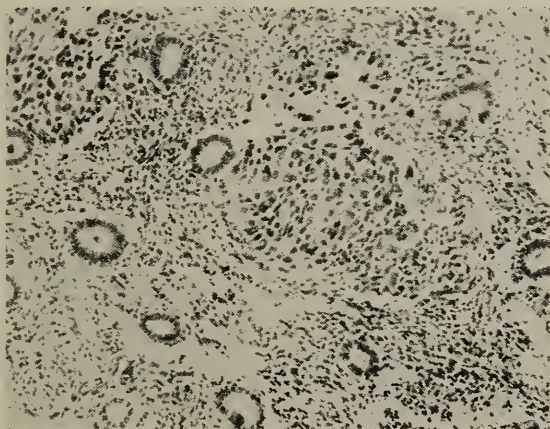


Fig. 2 Anaplastic tumor invading endometrial stroma. Note normal endometrial glands.

ginal biopsy were done. Because there appeared to be some free fluid in the cul-de-sac a colpocentesis was done and the fluid, serosanguineous in appearance, was sent to the Pathology laboratory. The fluid contained malignant cells. An undifferentiated squamous cell carcinoma of the cervix and vagina was reported.

DR. EUGENE GOLDMAN: All the specimens showed the lesion. I am going to show only the cervix and endometrium. An important thing to note in the cervical biopsy, (Fig. 1), is that there is an intact squamous epithelial lining on the surface which is entirely normal, and that within the subepithelial stroma there are large accumulations of cells with central masses of more darkly staining cells that represent the tumor. There is also tumor in vascular channels. At high magnification we see individual groups of cells that didn't suggest anything in the way of primary site. All that we could say at the time was that we had a malignant tumor, a carcinoma involving the cervix. The sections from the vagina were similar and also did not show a tran-

sition from normal mucosa to tumor. The endometrium is also infiltrated by tumor and it is striking to note the normal tubular glands of the endometrium with the completely anaplastic tumor around them. (Fig. 3) In other words, it is not a primary lesion of the endometrium either. The diagnosis given by Dr. Bustillo was slightly in error in that we really felt that this was an undifferentiated carcinoma, primary site uncertain. We would have put the cervix as the best bet although it could have originated in the vagina, uterus and in the light of the pelvic mass, have even come down from the ovary.

DR. BUSTILLO: Two days later on July 30, 1966, under local anesthesia, an abdominal exploration was done. Twelve hundred fifty (1,250) cc.'s of serosanguineous fluid was obtained from the abdominal cavity. The right ovary was enlarged, fixed and obviously involved with tumor. The left ovary, although smaller, was similarly involved. Peritoneal implantations were present. Palpation of the liver revealed multiple 5 mm. to 10 mm. size nodules which were interpreted as being malignant, metastatic disease. Biopsy of the right ovary was taken.

DR. E. GOLDMAN: This section from the ovary shows some similarity to the lesion in the cervix. Because of these abortive gland-like structures, knowing it came from the ovary and knowing that undifferentiated carcinoma of the ovary may have this appearance, we felt that this was a primary carcinoma of the ovary and in reviewing the slides of the lower uterine tract, we felt that they showed a marked similarity histologically and that most likely the first biopsies of cervix, uterus and vagina represented intraluminal spread from the ovary. The remote possibility of two primary carcinomas is still present. I think an even more remote possibility is that the lesion is primary of the cervix and metastasized to the ovary.

DR. A. GECHT: We were under the impression the patient had two primaries, a squamous cell carcinoma of the cervix and a poorly differentiated adenocarcinoma of the ovary. She was also known to have liver, lung and peritoneal metastases. An informal conference was held in order to decide what, if anything, should be done for this patient. Dr. Masterson, what would your advice have been had we been for-

fortunate enough to avail ourselves of it at the time?

DR. JOHN G. MASTERSON: I would like to commend the staff for an excellent workup of this patient. I think that it is only by stressing the need of thoroughly evaluating all patients with malignancies can we at all improve our end results. As I viewed the presentation and the slides shown I think I would have had the feeling this was probably a primary carcinoma of the ovary with metastases to the endometrium, to the cervix, vagina, as well as a distant metastases to the lung and, disseminated disease within the peritoneal cavity and to the liver. We know that carcinoma of the ovary in the advanced stages will not infrequently involve the lower part of genital tract as well as the intraperitoneal organs and distant sites. Certainly the biopsy that was taken showed a normal epithelial surface with no suggestion of any neoplastic activity and the tumor you saw in the stroma spoke for a metastatic lesion.

I would first comment on the exploration. If you have substantiated through your workup that the patient has distant metastases, and that you have confirmed she does have this malignancy, why subject her to an exploratory laparotomy? I would subscribe to what was done here because on occasion we are fooled as to where the primary is. Having confirmed then that this was a primary of the ovary, with the stage of the disease as we have indicated, I believe we would have probably employed chemotherapy and the drug we have had the most favorable experience in carcinoma of the ovary, is the alkylating agent, Chlorambucil.

We began our work with Chlorambucil back in 1956 and have, during the last ten years, been personally responsible for over three hundred patients with some disseminated ovarian carcinoma who have been treated with this agent. We now have a group of patients who with disseminated ovarian carcinoma have been sustained in remission for five or more years under Chlorambucil therapy. The dose we most often employ is 0.2 mgs. per kilogram of body weight. This daily dose is divided into three equal portions and given post prandial for a period of six weeks. If we do not observe objective control as reflected in regression of measureable lesions by the end of six weeks, we see no advantage in

pursuing the therapy further. In our own experience we have seen 50 percent of the patients with actual objective regression in measurable lesions; another 10 percent have shown failure to have further progress of the tumor growth and therefore, could be considered objective control. Of these 60 percent of the patients, about 85 percent have shown what we call biological leukopenic state during the following of their therapy. This has been such a consistent observation that we now believe we can utilize it as a prognostic index of a patient who is going to respond and a patient who is going to fail to respond. Furthermore, we utilize this chronic leukopenic state as a measure of determining and controlling our maintenance therapy when this is employed.

In our original group of patients treated with Chlorambucil, those who did respond to an initial course, would have an exacerbation of their disease if they were not kept on maintenance therapy. When we then tried to re-treat them, we were unsuccessful whether we employed Chlorambucil or any other agent. It is essential therefore that the patient who does respond be maintained on Chlorambucil for the remainder of her time of remission.

The regime which we employ is a course of two to three weeks with rest periods of two weeks. We endeavor to keep these patients with a peripheral white blood count of between 1,500 to 4,000. Obviously, this is not an approach that can be successful in every patient. Of the 60 percent who have responded, we have been able to maintain one-quarter of these in remission for two or more years. Nineteen patients have been followed five or more years under this maintenance therapy.

A recent study at M.D. Anderson Hospital in Houston using Phenylalanine mustard is producing comparable results. In 1961 they were very enthusiastic about using radiation therapy but since that time there has been apparently a change of philosophy related to the results with the use of Phenylalanine mustard.

I think it is well to point out we are dealing with perhaps 12 to 15 different varieties of carcinoma of the ovary rather than a single type of malignancy. Our experience indicates that each variety has its individual response rate to the alkylating agent. For example, we have found the

cystadenocarcinomas and the mucinous cyst adenocarcinomas are the most responsive whereas the malignant Teratomas, granulosa cell carcinomas are the least responsive. Unless you have a response that is maintained a minimum of six months it is not worth while considering and discussing the effectiveness of a drug.

We have seen an appreciably increased instance of these patients developing herpes, or as it is commonly referred to, "shingles." Some 15 percent of these patients have had one or more attacks of shingles on maintenance therapy. I don't know the explanation of this other than perhaps a relationship of viral origin of malignancies.

I think that one final word should be mentioned about the fact that in using chemotherapeutic agents, the clinician must be familiar with the dosages and toxicities that are associated with it and the fact that each agent has its own toxic reaction and that what it is pertinent to one may not be pertinent to another.

There have been some small studies in regard to combining Chlorambucil with radiation. We do not have evidence to suggest that the combining of these two modalities enhance your response rate. As a matter of fact, in practice, if you employ these drugs to a toxic range you must of necessity reduce your radiation therapy dosage, otherwise you overwhelm the patient.

DR. WILLIAMS: We used Chlorambucil, a drug I have also had the best luck with in ovarian carcinoma. We did not give her radiation to begin with although I eventually wanted to because I am completely surprised today with this single diagnosis.

DR. R. SCHMIDT: The progress films of the chest demonstrate continued improvement compared with the original films. In the most recent film taken today the process appears to be no longer present. (Fig. 3 and Fig. 4.)

DR. GOLDMAN: A cervical biopsy was taken within the last month. Without knowing all the details of the history we felt that there was residual carcinoma but that this carcinoma was showing radiation effect. After sending out the report, we learned that this radiation effect was not the result of x-ray irradiation but one of Chlorambucil. (Fig. 5)

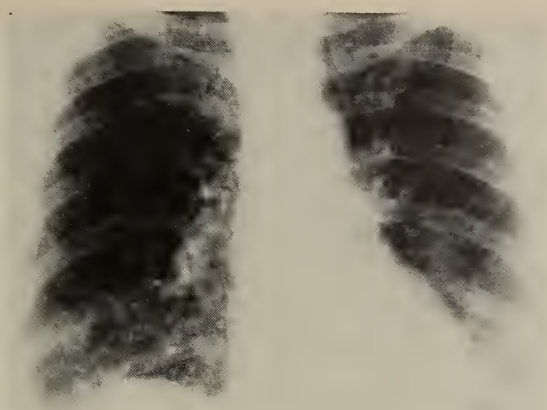


Fig. 3 Round areas of density in lung representing metastatic foci.

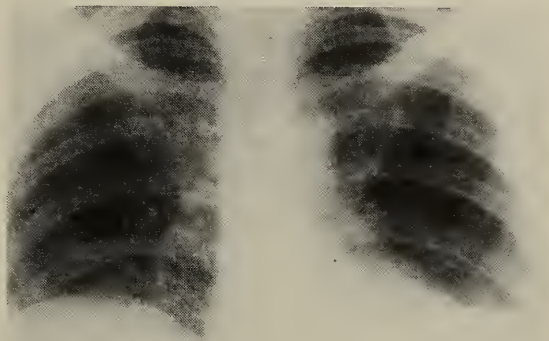


Fig. 4 Metastatic process no longer present.

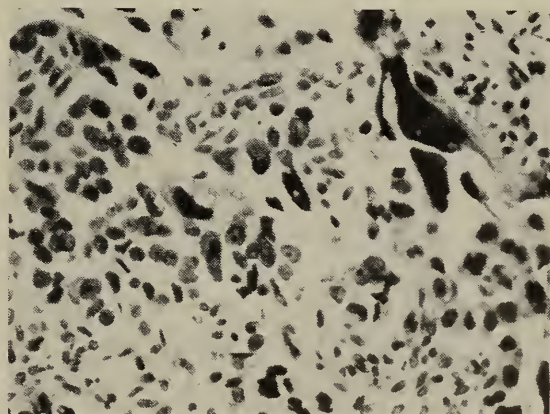


Fig. 5 High power view of tumor cells in cervix following Chlorambucil therapy. Note "radiation effect."

DR. WILLIAMS: I examined this lady just before she left to go to Canada and at that time the tumor mass in the right side of the pelvis was approximately one-third the size it was in July at the time of exploration. The tumor mass on the left is practically one-half the size it was at the time. She has no evidence of ascites. Her general appearance is that of a healthy woman.

(Continued on page 417)

A Local Community's Evaluation of The Dextrostix Test and Their Outlook Toward Diabetes Screening

By WAYNE MESSICK, M.P.H., AND ISMAEL B. MORALES, B.S./ Quincy

Practicing the concept of early case detection by utilizing existing screening methods should be an easy matter for public health departments and their personnel. Yet, not many utilize simple screening techniques that are currently available. For example, diabetes exists in the population in sufficient numbers to demand focus and implementation of known screening test to find cases early.

Leadership in public health, with ample consultative services available from the Public Health Service and the American Diabetes Association, have at their fingertips the methods and materials to better detect and control diabetes. Medical resources in most communities are sufficiently available and the reservoir of cases are waiting to be found and placed under medical control. Health Officers, physicians and others concerned with public health can well afford to devote time and energy to diabetes detection and research.

15 Years of Diabetes Screening

The Adams County Health Department and Adams County Medical Society of Quincy have jointly been conducting diabetes screening for 15 years, continuously improving their screening methods with the increased knowledge resulting from research. The methods used in this commu-

ity program have been versatile in that they can be applied to both small and large communities. Instead of the most commonly used once yearly "crash" type of diabetes screening program, the Health Department and Adams County Medical Society schedules monthly diabetes screening sessions. Personnel annually visit the smaller communities of the county to conduct diabetes screening, acquiring the co-operation and assistance of local groups to co-sponsor and promote the screening clinic in their area.

During the year of 1966 the Adams County Diabetes Screening Program conducted an evaluation of the Dextrostix Reagent Stix* screening test for the detection of diabetes. This paper reports on the study.

Community Educational Program

Prior to the diabetes screening clinics, the health department conducts an educational program in the community with stress upon proper food intake two hours prior to screening time and encouraging high risk groups such as blood relatives of previously known diabetics, overweight people, mothers that have delivered babies weighing nine pounds or more, and the population over forty years of age to attend the clinic.

* Ames Company, a Division of Miles Laboratories, Elkhart, Indiana



Wayne Messick, MPH, (left) is public Health Administrator for the Adams County Health Department. He received his training in public health at the University of North Carolina. Ismael Bob Morales, B. S., is a public health advisor in the Chronic Disease Branch, Heart Disease Control Section, Puerto Rico Department of Public Health.



A total study population of 1,128 people that included 652 females and 476 males was screened by both Dextrostix and the Wilkerson-Heftmann test (Glover Edwards unit). The mean age of the study population was 59.1 years with approximately 80 per cent of the people over 40 years of age. There were 552 (48.8) people in the study population with a family history of diabetes and 159 (24.3 per cent) females that gave birth to children weighing nine pounds or more.

The blood samples for the Dextrostix and Wilkerson-Heftmann test were collected at the same time as close to two hours as possible following a high carbohydrate meal. Capillary blood was used for both the Dextrostix and Wilkerson-Heftmann screening methods. The technicians doing the testing were trained by Eli Lilly Drug Co. personnel in the Wilkerson-Heftmann method and the Ames Drug Co. in the Dextrostix method.

Autoanalyser Tests

Blood sugar determination of 130 mg. per cent 100 ml. by either test were considered as positives and tested by autoanalyser. The venous blood specimen for the autoanalyser test was collected in a vacutainer containing a sodium fluoride preservative and sent to the local community hospitals for processing. One hour prior to the collection of venous blood for the autoanalyser test the screenees were asked to drink a Dextrose Cola beverage containing 75 grams of carbohydrate solution (Hydrolyzed Corn Starch) while fasting. Persons with a blood sugar determination by autoanalyser of 160 mg. per cent or greater were referred to their physician for a conclusive diagnosis. A report of the testing results was sent by mail to the physician of those persons screening positive. The Adams County Health Department public health nurses followed up all cases referred thirty days after the initial referral to acquire a disposition from the person screened and/or from their physician. A diagnosis on all persons referred to their physician for further medical evaluation was attained.

Recommended Procedures Observed

To assure maximum accuracy and reliable results with each diabetes screening test under evaluation, the recommended procedures from the Ames (Dextrostix) and

Eli Lilly (Wilkerson-Heftmann) Co. were strictly observed. Those persons screening 130 mg. per cent 100 ml. or over by either Dextrostix or Wilkerson-Heftmann screening test were given a Dextrose Cola beverage containing 75 grams of carbohydrate solution (Hydrolyzed Corn Starch) to consume at a specified time the following morning after fasting overnight. The person was requested to record the time he consumed the drink and to quickly consume the beverage taking no longer than five minutes to drink it. He was asked to be present at the Adams County Health Department Diabetes Clinic 50 minutes after consumption of the drink so that a venous blood specimen could be collected exactly one hour after drinking the beverage. The venous blood specimen was collected in a vacutainer containing a sodium fluoride preservative and processed by one of the community hospitals laboratory autoanalyser. Both hospitals in the community use the Ferricyanide and whole blood in their autoanalyser testing for blood sugar determination. Those persons with blood sugar determinations of 160 mg. per cent by autoanalyser test were referred to their physician for further diagnostic evaluation.

Cost of Screening Minimized

By using these screening methods, the sponsoring agencies have been able to keep the cost of screening for diabetes at a very minimum and yet maintain good sensitivity and specificity necessary for the early detection of unknown diabetics. The estimated cost of screening by the Adams County Health diabetes program in 1966 was 61 cents per person. The cost to detect a previously unknown case of diabetes was \$32.74 per patient. These estimated costs include screening materials, personnel, salaries, postage, and all other costs.

For clarification, positives in this program were those persons with a blood glucose determination of 130 mg. per cent or greater by Dextrostix and/or Wilkerson-Heftmann test. Previously unknown diabetics are those persons that are positive by Dextrostix or Wilkerson-Heftmann had a glucose determination by autoanalyser of 160 mg. per cent or greater and were diagnosed by their physician as diabetics.

In this evaluation the Wilkerson-Heftmann diabetes screening test had 180 (15.8 per cent) positives and detected 24 (2.1 per

cent) previously unknown diabetics from the study population. The Dextrostix had 233 (20.5 per cent) positives and detected 18 (1.5 per cent) cases of previously unknown diabetics from this study.

Evaluate Accuracy of Readings

An evaluation was conducted to determine whether or not the technicians were accurately reading the Dextrostix test. This was done because the color reaction obtained by Dextrostix will vary from light to deepening shades of gray, blue, and blue-purple, and can be difficult to interpolate. The basic difficulty encountered by this program's technicians was associated with reading blood glucose determinations in the range of 90 mg. to 130 mg. per cent.

For evaluation purposes, the screenees who had initial glucose determinations of 90 mg. to 130 mg., according to the color blocks of the dextrostix chart, were classified as "doubtful positives." In a retest of this group, by the autoanalyser method, only one person was found positive and referred to his physician, and was diagnosed negative.

Because of these results the technicians were instructed to classify as negative all screenees with questionable blood glucose determinations and regard as positive only those persons with a sure 130 mg. per cent or over.

Conclusions

The efficiency of a commonly used diabetes screening method in a study population of 1,128 people was evaluated. The capability of a small community doing diabetes screening efficiently and economically has also been discussed. Under the conditions of the study the Wilkerson-Heftmann test seemed to be more effective than the Dextrostix in sensitivity and specificity for the detection of previously unknown diabetics. The Wilkerson-Heftmann test had a lower percentage of positives and detected more previously unknown diabetics than the Dextrostix in this evaluation. The Dextrostix had 4.7 per cent more false positives and .6 per cent less the detection of previously unknown diabetics. An influencing factor that should be considered in the evaluation of this study is that the technicians doing the Wilkerson-Heftmann test had many years of experience which had allowed them to become efficient in its oper-

ation. On the other hand, the personnel doing the Dextrostix, although trained to perform the test, did not have the experience that would bring about the maximum accuracy desired when performing this test. With experience and an evaluation of the questionable readings by technicians doing the Dextrostix test a better sensitivity and specificity may be obtained. The convenience of the Dextrostix test with its ability to do the test faster than the Wilkerson-Heftmann, the simplicity in setting up for a screening clinic and advantage of transportability, is a decided asset. Neither the Wilkerson-Heftmann or the Dextrostix diabetes screening test would be suitable to use in a screening program without the support of a secondary test by auto-analyser on all positives detected. By following all these positives with an autoanalyser test, good sensitivity and specificity for the overall program can be maintained and over referring can be controlled.

This investigation of the Dextrostix diabetes testing method illustrates how local health departments can keep up with progress in diabetes screening brought forth through research. With this philosophy and approach, the Adams County Health Department has been able to continue an effective economically feasible program in diabetes screening that maintains good specificity and sensitivity, effective promotion through the news media, emphasis in screening high risk groups, good follow-up on all referrals and education in the community regarding the health problem of diabetes. In the year of 1965 through 1966 the diabetes screening clinic of the Adams County Health Department screened 1,900 people and detected 37 cases of previously unknown diabetics, (2 per cent of the population screened). With most small and large communities developing diabetes screening programs, the early detection and treatment of undiagnosed diabetes could be possible and the life expectation of these people may possibly be extended.

During 1967 the Veterans Administration briefed hundreds of thousands of servicemen in Viet-Nam on their veterans benefits. VA representatives also interviewed and gave vocational counseling to thousands of additional servicemen in Viet-Nam, at U. S. separation points and in stateside military hospitals.

Your Drug and Therapeutic Committee Reports

Oral Diuretics Agents

The thiazide diuretics have changed physicians' habits in the use of effective diuretics therapy from intermittent injections to continuous daily therapy. However, in most patients on daily treatment, the total diuretic effect of the thiazides is not great enough to produce serious problems, especially if the sodium intake is not severely restricted. The aldosterone blocking agents can augment the potency of diuretic therapy when given with thiazides. They prevent potassium depletion and balance some of the difficulties of a continuous potent diuretic routine.

Two new agents, Ethacrynic acid [Edecrin-Merck] furosemide Lasix [Hoechst], extend the diuretic armamentarium to patients very refractory to diuretic therapy. They are destined to complicate physician's habits of daily therapy unless their great ability to induce diuresis (not shared by any previous agents) is appreciated. Edecrin and Lasix are increasingly effective over a wide dose range. Both act very rapidly, usually within an hour, when given orally; and within 10 minutes when given intravenously. Their major effects are dissipated after about six hours. At lower dosages they offer no great advantages or disadvantages over the older thiazides.

The effect of Edecrin (ethacrynic acid) on diabetes mellitus has not been adequately determined. At higher dosages they are several times more effective in producing a diuresis in many patients than the normal physiologic process of fluid transfer from the interstitial space into the blood stream. This is especially true in patients with edema due to disorders other than congestive heart failure.

Therefore, in patients receiving dosages greater than 150 mg. per day, care must be taken to prevent severe and rapid dehydration along with hypokalemic alkalosis. In such patients it appears that the "older" routine of intermittent diuresis (therapy for one or two days, then off for two days) offers the best hope for prevention of these electrolyte complications. During maintenance therapy, a lower daily

dosage may be given continuously. However, intermittent therapy offers good control in most patients with lesser risks of dehydration and/or electrolyte depletion.

GUEST CONTRIBUTOR

Clarence L. Gantt, M. D.
Associate Professor of Medicine
College of Medicine
University of Illinois

Tumor Conference

(Continued from page 413)

DR. MASTERSON: We might also comment on another concept which we have not discussed and that is, is there a place for surgery in a patient who has, shall we say non-resectable ovarian carcinoma at the time of an original exploration but who responds to chemotherapy and then becomes operable? We took a group of patients who had non-resectable diseases at the time of exploration and who became operable in response to chemotherapy and re-explored them carrying out surgical resection. Their prognosis and survival time was no different than the group who did not have further surgery. We don't feel inclined to recommend re-exploration and to attempt to carry out more definitive surgery. Another item that comes up to which I do not have the answer—Why continue to treat patients who have been treated five or more years under this maintenance regimen, the vast majority of whom have no evidence of the disease? Unfortunately, we do not have the answer. I have approached several of these patients now and have said to them we have no indication to say that you have residual or active disease at the moment and therefore, you may be getting therapy unnecessarily. Would you like us to stop? All of them have asked what will happen. I honestly have to say, I don't know."

The Veterans Administration administers the educational assistance program for Post-Korean Conflict veterans. In that role it continues to guide the largest program of adult education ever undertaken.



THE VIEW BOX



Fig 1

BY LEON LOVE, M.D.

Director, Department of Diagnostic Radiology, Cook County Hospital, and Clinical Professor of Radiology, Chicago Medical School

This 54-year-old W/M entered Cook County Hospital with a chief complaint of backache for the past five years. The pain was chiefly localized over his left flank, but there had been episodes of colicky pain radiating down to his groin. He had a history of chronic alcoholism. Physical examination revealed tenderness in the left flank. Urine contained 2+ albumen, 15-20 white blood cells. A scout film of the abdomen (Fig. 1) and upper GI series was done. Note that Fig. 2 is an upright spot film. (Attention is called to the floating character of the multiple calculi.)

WHAT'S YOUR DIAGNOSIS?

- 1) Pancreatic lithiasis
- 2) Splenic calculi
- 3) Calculous hydronephrosis
- 4) Tuberculosis of the kidney

(Answer on page 422)



Fig 2

EDITORIALS



DEAFNESS IN YOUNG CHILDREN

Johnston and his group made a detailed study of factors relating to the onset of deafness in 188 youngsters under five. Fifty-four children with normal hearing and of the same age were used as controls. Questions were prepared to elicit specifics in both parents and the child's histories. In 50 per cent of the children, hearing loss was not suspected until sometime between eight months and four years of age, although the majority probably were deaf within the first two months.

An analysis of the causes for deafness revealed that maternal illnesses in the first trimester of pregnancy occurred most frequently. Thirty-three had rubella, three, influenza, and one each, had chicken pox and scarlatina. Blood incompatibility caused deafness in five youngsters and in four others, the loss apparently followed meningitis. Heredity was causative in 15 cases and trauma in one. The history was normal in nine.

There were frank abnormalities in the histories of the 46 remaining children, but the causal relationship of these incidents to deafness is not known. Some of the infants

weighed less than four pounds, eight ounces at birth; others were delivered with the cord around the neck, body blueness, and breathing difficulty. Johnston considered maternal bleeding, maternal influenza after the first trimester, and streptococcal sore throat or mumps during pregnancy more important. The same could be said of infants with neonatal jaundice or of those who received mycin drugs in the first month of life. These factors were more striking when compared with the rates among the 54 hearing children.

Among the deaf group, there also was a higher incidence of maternal thyroid deficiency, breech delivery, paternal smoking, and the ingestion of cod liver oil by the mother. There also was a reduced tendency of fetal movements in the third and fourth month. Forcible delay of delivery was reported surprisingly often. As stated previously, it is not known whether these differences between the two groups are meaningful.

T. R. Van Dellen, M.D.

Johnston, Philip W.: Factors Associated with Deafness in Young Children, Public Health Reports 82:1019 (Nov.) 1967.

THE 90-YEAR-OLD HEART

An investigation of the cardiac status of 100 nonagenarians was conducted at the A. Holly Patterson Home for the Aged and Infirm in Uniondale, N. Y. Only a few were free from objective cardiac pathology, but

it was surprising how few had cardiovascular complaints. Myocardial infarctions were conspicuous, only by their relative rarity. Only seven residents had an impaired carbohydrate metabolism as induced by a

two hour postprandial blood glucose of over 130/100 cc. All had been physically active. Blood cholesterol values were low in all subjects.

The group studied consisted of individuals from 90 to 99 years old, with an average age of 92.5. A heart that weathers the storms of 90 winters is bound to be damaged and the investigators found this to be true. These patients had not lived out their years with normal hearts. The electrocardiogram showed abnormalities in the majority (89 per cent). Sixty-eight were asymptomatic, except perhaps for extraneous discomfort associated with advancing years. Moderate cardiovascular symptoms were found in 15 and severe dyspnea in 17. Eleven of the latter also had angina pectoris.

Physical examination of the heart was negative in 34 and moderately abnormal in 57. Eight subjects had signs of mild con-

gestive heart failure and refractory decompensation was noted in nine. Only 25 of the group had diastolic hypertension (90 or over) and 12 had systolic levels exceeding 150 mm. Hg. Chest X-rays revealed tortuosity and calcification of the aorta in nearly all. Forty-one had mild to moderate enlargement, but only two had marked cardiomegaly. Despite the EKG abnormalities, one finding was conspicuous by its absence; no instances of atrioventricular or third-degree heart block were found. The authors concluded that this type abnormality is incompatible with longevity. Sixteen who had evidence of old myocardial infarctions exhibited less clinical cardiac deficits than average.

T. R. Van Dellen, M.D.

May, Siegmund H.; Avila, Vincent, and Margouloff, Donald.: Hearts in the Tenth Decade. Arch. Internal Med. 127:141 (Feb.) 1968.

How Long Do Presidents Live

This is the season—just before a national election year—that sparks the perennial question about the longevity of American presidents, and the effects of the demanding burdens of office upon the official White House occupants.

A study by statisticians of Metropolitan Life Insurance Co. sheds some interesting light on the question by comparing the longevity of our Presidents with that of their running mates and the unsuccessful Presidential candidates for office.

Our Presidents, coming mainly from the more favored segments of our society, usually have been vigorous men, tenacious of life. Nevertheless, their average duration of life after taking office has been shorter than might have been expected from mortality conditions prevailing at the time of their inaugurations. Firm conclusions on this score are not possible inasmuch as our deceased Presidents number only 32. The varied backgrounds and styles of the men who have filled the world's No. 1 job confound any proposition that the Presidency attracts men of similar physical type or disposition which might be associated with a shorter lifespan.

The 28 deceased Presidents who died natural deaths (i. e. excluding those who were assassinated) lived an average of 70.7 years, or about three-tenths of a year long-

er than the average years lived by the 24 deceased Vice Presidents, and about six-tenths of a year longer than the 40 deceased unsuccessful candidates. (None of the Vice Presidents or unsuccessful candidates was assassinated.)

The Presidents who died natural deaths lived about 1.5 years less than expected. In this respect, they fared somewhat better than the Vice Presidents or the unsuccessful candidates, who fell short of their life expectations by around 2.6 and 2.2 years, respectively.

While the record of the Presidents who died natural deaths does not support the proposition that the strain of office shortens the lives of our Chief Executives, the picture is radically altered when the four assassinated Presidents are included. Then, the average length of life of all of our 32 deceased Presidents turns out to be 68.5 years, which is approximately 3.6 years below their average expectation of life at inauguration.

A stronger case for the adverse effect of the burdens of office on the longevity of our Presidents can be made out of the record since 1860. The Presidents since then have, on the average, been more shot-lived than those who preceded Lincoln. The 15 Presidents from Washington to Buchanan averaged 74.2 years, or about 1.3 years

(Continued on page 550)

Lung Cancer Death Rates Still Rising; Uterus Cancer Down

Death rates from cancer of the lung continue to rise to record heights, while death rates from cancer of the uterus continue to decline.

The American Cancer Society's "1968 Cancer Facts and Figures" issued recently shows that deaths from cancer of the lung will mount to an all-time high, with 55,000 deaths estimated for 1968 as compared to 52,000 this year.

A decline is indicated for the death rate from uterine cancer (though the number of deaths this year—13,500—remains the same because of population changes). This is a continuation of the trend which has cut the death rate in half from this type of cancer in women over the past 25 years. The ACS attributes the increasing number of lives saved in large part to the wider application of the Pap test which helps detect the cancer in its early and more curable stages.

More than 50 million Americans now living will eventually develop cancer—if the present rates continue, the Society's booklet reports.

The figure of over 50 million Americans means that one in every four persons will get cancer and it will strike approximately two of three families.

The death rate of stomach cancer continues to decline—the estimate for 1968 is 17,000 deaths as against 18,000 this year. "1968 Cancer Facts and Figures" notes that there has been a 40 percent decline in mortality from stomach cancer in the past 20 years, for reasons yet unknown.

"There are now 1,400,000 Americans, alive today, who have been cured of cancer," according to the ACS publication. By "cured," the Society means that they are without evidence of the disease at least five years after diagnosis and treatment. Actually, the Society notes that there are more than 2,000,000 Americans cured of cancer, because 700,000 ex-cancer patients will not formally be counted as cured until they have completed the five years.

About 200,000 Americans will be saved from cancer in 1968, the publication reports. It also notes that if present rates continue, 100,000 cancer patients will die in

1968 who could be saved by earlier and better treatment. "1968 Cancer Facts and Figures" also shows that in 1968 about 915,000 Americans will be under medical care for cancer; there will be about 600,000 new cancer cases (diagnosed for the first time) in 1968.

In 1968 an estimated 4,500 children under the age of 15 will die of cancer, about half of them of leukemia, which is cancer of the blood-forming tissue and bone marrow. The Society's Annual Meeting was informed that on Sept. 1, 1967 there were 61 ACS grants for more than \$2 million that were directly or indirectly related to leukemia. Many cancer experts believe that if drugs or vaccines can be found which will cure or prevent cancer, they will be successful first for leukemia and the lymphomas. Newly developed drugs and combinations of drugs have arrested leukemia for longer periods of time than ever before. But there is no preventive or cure as yet, the Society reported.

According to the Society publication, cancer of the colon and rectum will strike about 73,000 Americans in 1968, more than any other type of cancer except skin, and it occurs about equally in men and women. Some 45,000 die of it annually, although almost three out of four patients might be saved by early diagnosis and proper treatment.

Approximately 1,000 more deaths from cancer of the breast are estimated in 1968 than occurred in 1967. The 1968 estimate is for 65,000 new cases and 28,000 deaths. Cancer of the breast remains the leading cause of cancer death in women.

Servicemen now being discharged from active duty have the protection of their Servicemen's Group Life Insurance policies extended for 120 days at no cost to them. During that period they are entitled to apply for and receive their private life insurance at regular rates, regardless of any disabilities they have incurred in the service. They may apply to any of more than 500 commercial insurance companies which participate in the program.

— THE VIEW BOX —

(Continued from page 418)

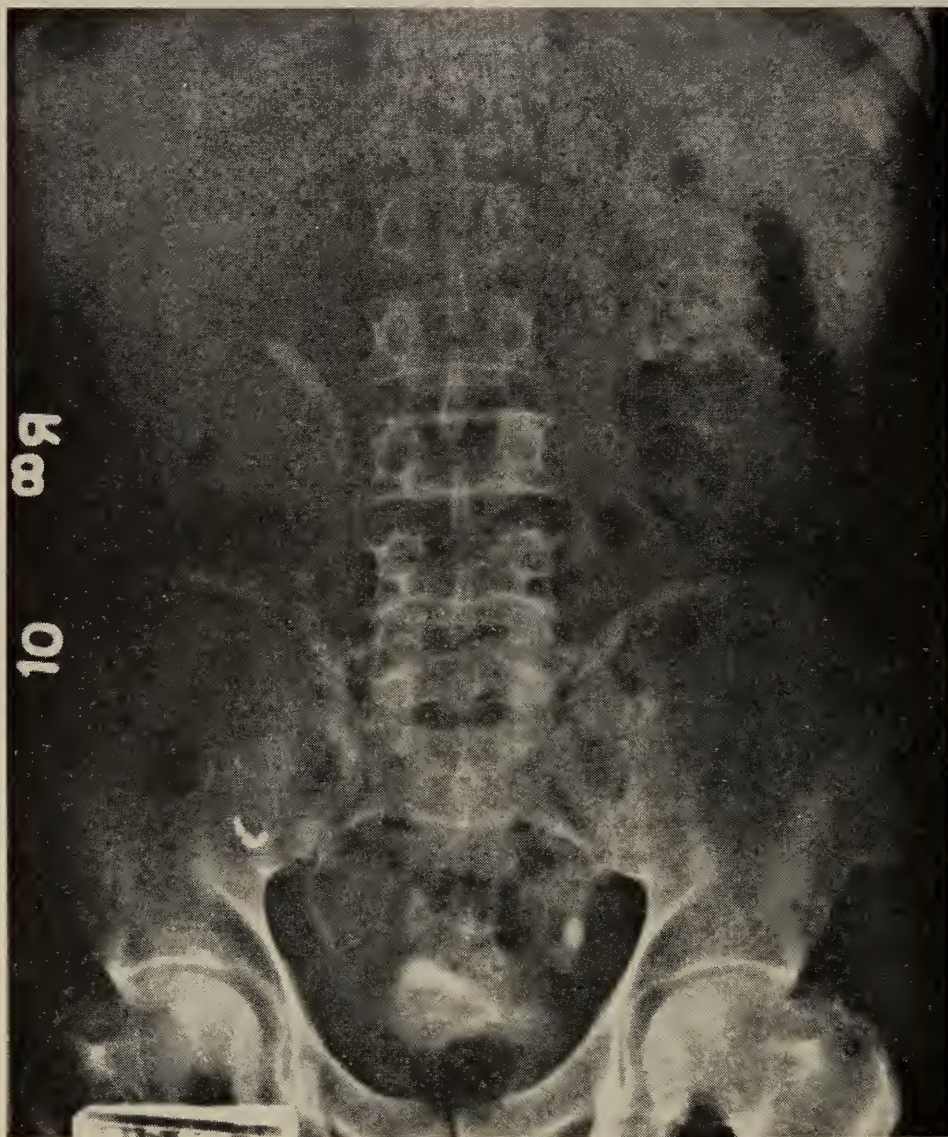


Fig 3

DIAGNOSIS

Multiple calculi in a markedly hydronephrotic kidney. I.V.P. (Fig. 3) reveals non-function of an enlarged left kidney containing numerous small calcifications which layer out on the upright film (the calculi are heavier than the fluid which contains them), and sink to the most dependent portion of the hydronephrotic sac. In a way this is similar to gall stones which layer out on upright examination. Calculi which collect in sacs such as diverticula of the calyces or diverticula of the urinary bladder and in large hydronephrotic calyces tend to be small. Stasis and infection follow obstruction and lead to chronic pyelonephritis and/or renal atrophy.

At surgery a large hydronephrotic kidney was removed with numerous small calculi noted in all dilated calyces.

Fabray's Disease

A skin rash with a peculiarly restricted distribution begins when the patient is about 10 years old or just before puberty.

Within a few years, he begins to have pain in his arms and legs.

His kidneys begin to fail and normal wastes are not properly eliminated.

Between the ages of 30 and 60 the patient dies from kidney failure. He often shows complications of cerebrovascular disease, cardiac abnormalities, and colitis.

This description of Fabray's Disease, or Angiokeratoma Corporis Diffusum, is based upon a detailed study of five cases by a University of Chicago research scientist who made some new observations which may help in dealing with the disease.

A report on the study co-authored by Dr. V. William Steward, Director of Neuropathology at The University of Chicago and Senior Registrar at Maida Vale Hospital for Nervous Diseases, London, was presented early in March at the annual meeting of the American Association of Pathologists and Bacteriologists in Chicago.

Caused by Genetic Abnormality

According to Dr. Steward, the disease is becoming more widely recognized and more cases are turning up.

The disease is caused by a genetic abnormality which affects the mechanisms controlling fat production in the body. It is "fully expressed only in males," he states, and is thus "inherited in a manner similar to that of hemophilia" which involves impaired coagulation of the blood and a strong tendency to bleed.

One of the primary findings of Dr. Steward's study was that patients with the disease have a widespread striking deposition of complex lipids, or fats. These deposits are found in selected parts of the nervous system, in the renal system, and in the heart areas derived, primarily, from a restricted part of the embryo—the neural crest cells. The deposits are composed mainly of di- and tri-hexosides.

The accumulated materials, he believes, are probably normal constituents or products of breakdown of the complex fats associated with nerve cells and their sheaths.

Pain Origin in Doubt

Dr. Steward's findings, based on examination of patients with the disease and after their death, indicate pain in those with the

disease may not be a result of damage to the brain and higher autonomic centers. However, he adds, aside from a few previous reports of fat deposition in various areas of the body, "no detailed descriptions are available to help decide such a site of origin for this most distressing symptom."

In any case, according to Dr. Steward, it is difficult to ascribe production of pain to "damage" or "involvement" of any one part of the nervous system. Pain, he explained, probably has many anatomical and interconnected levels. However, involvement seen in Fabray's Disease "is very much related to those pathways conveying sensations and possibly pain."

Finally, according to the report, the high accumulations of di- and tri-hexosides found in kidney tissue of patients with the disease appear to be due to a deficiency of an enzyme, probably genetically affected, which fails to catalyze or make use of the incoming fats.

Drinking Involved in Home Accidents, Company Finds

A study by The Metropolitan Life Insurance Co. of fatal home accidents among its policyholders indicates that alcohol plays an important role in such accidents among young adults and the middle-aged. Home accidents among persons in their prime working years, 15-64, account for about 8,300 fatalities and more than 8.5 million non-fatal injuries annually.

The Metropolitan study covered persons aged 15-64 who held ordinary life insurance policies and who died in home accidents during 1964 and 1965. It involved 537 male and 310 female fatalities, of which nearly 15 percent of the former and about 20 percent of the latter were found to be associated with drinking.

While millions of Americans drink without subjecting themselves to any appreciable hazard, the insurance study provided evidence of the extent to which injudicious drinking can become dangerous, even around the house. Reports on the measurement of blood alcohol levels were available for only a small number of the fatally injured policyholders. But time and time again, information was developed that the victim had been drinking heavily, was a

(Continued on page 543)

Film Guide

The growing increase in the number of excellent medical teaching films over the past several years is reflected in the rise in requests for motion pictures from the Film Library of the American Medical Association.

In addition, there is a greater appreciation of the value of well-prepared motion pictures in graduate and postgraduate medical education, according to Ralph P. Creer, director of the medical motion pictures and television section of the AMA.

As a further indication as to the need for motion pictures by physicians and paramedical schools (allied professions; other than physicians), the supply of the Catalog of Selected Medical and Surgical Motion Pictures was exhausted within six months, and thus went out of print.

A total of 17,328 medical and health films were lent to physicians, hospitals, medical schools or other professional groups by the AMA Film Library during 1967.

Most of the films were employed as educational material for physicians, medical students, nurses and paramedical students.

The number of bookings was the greatest ever recorded at the library, increasing 23 per cent over 1966 and 49 per cent over 1965. Total bookings have increased each year since 1955 when 3,007 were recorded.

Analyzing 1967 film bookings further, he said that the largest single users of films from the AMA library were civilian hospitals and schools of nursing. Ninety-two U. S. medical schools used the services of the Film Library during the year. Paramedical schools were increasingly heavy users, accounting for over 10 per cent of the total bookings.

The library now consists of 2,453 copies of 502 films. The total includes 128 health films which can be used by physicians who are invited to address lay groups. A current list of these films is now available.

* * * *

International Film Bureau, Inc. is distributing "Homefires," a 28-minute, B/W, 16 mm. film produced by the Mental Health Film Board. Presented by the Department of H. E. W., Department of Education, the film shows the various benefits of Homemaker Service by observing one worker in three of her assignments.

This special "homebuilding" service may remove the necessity of institutional care for elderly people by assuming their domestic chores, upgrade standards of living in families where the mother is indisposed, or recognize and deal with latent emotional problems of families being served. "Homefires" will be of particular interest to health, education and welfare agencies, schools of social work and nursing, community groups and the general public. A 7-page discussion guide is available with the film, upon request. Contact the International Film Bureau, 332 S. Michigan Ave., Chicago, 60604.

* * * *

To inform health leaders and community groups of the value and function of the comprehensive Community Mental Health Center, a new 16 mm., B/W, 28-minute sound film entitled "Bold New Approach" has been produced. The Mental Health Film Board has produced this for the National Institute of Mental Health. The film reviews the many items of legislation passed leading to the establishment of Community Mental Health Centers. As a psychiatrist describes to an architect the various components and services of a model center, a design is produced which is endorsed by civic leaders. At intervals, scenes of actual mental health programs illustrate the five essential services of the center. Special services are demonstrated as well as coordination of rehabilitation and other programs. The film is available on free, short-term loan from the National Medical Audiovisual Center (Annex), Chamblee, Ga. 30005.

* * * *

Schering Corporation, an international pharmaceutical company, received a first prize gold medal for its film "Corps Profound" at the recent 10th International Film and TV Festival of New York. "Corps Profound" is a 22-minute color film intended as an educational film for physicians. It has been described as a provocative, visual inspection into many organ systems only rarely seen in situ. The film shows intricate workings of the human body through use of a special universal endoscope. It is loaned free to medical and paramedical groups through Association Films, Inc., 600 Madison Ave., New York.

The 28-minute color film, entitled "Horizons Unlimited," after the AMA's health careers handbook of the same name, gives brief on-the-job glimpses of men and women serving in career pursuits highlighted in the publication. To give viewers greater insight as to the length of preparation and particular scope of specific professions and occupations, "thought voices" are utilized in some segments of the film.

The University of Kansas Medical Center, Kansas City, served as the setting for the film, which will replace the time-dated film, *Helping Hands For Julie*, developed by the AMA in cooperation with E. R. Squibb & Sons, in 1959.

The new film was developed solely by the AMA. Physicians, medical societies and other medical groups should place their orders for showings, stating preferred and alternate dates, with the Films Section, AMA, 535 N. Dearborn St., Chicago, 60610. Schools and other non-medical groups should direct their requests for loan of the film to Modern Talking Pictures, Prudential Plaza, Chicago, 60601.

* * *

A 40-minute color film, "Hands of Action," depicting recommended procedures for handling a number of emergency health care situations, is now available on a free loan basis from the Public Health Service. The film, designed for use by instructors conducting training programs for operators of emergency vehicles, outlines recommended procedures for handling of blocked airways, bleeding, open wounds, and broken bones. In 16 mm. and sound, the film was produced by the Trauma Committee of the North Carolina Chapter of the American College of Surgeons. For loan of the film write the National Audiovisual Center (Annex), Chamblee, Ga. 30005, or the State of Illinois Department of Health.

* * *

"What a Wonderful World to Hear" is a full color film strip with related sound record, demonstrating the hearing process, loss of hearing, and the history of hearing aids. Introduced by Keystone Sight and Sound Inc., Harrisburg, Pa. 17101. Also discussed are the various types of hearing aids, their use, and reasons for purchasing a hearing aid. The strip is suitable for both home and office use as well as group showings. It is available from the agency named above.

A new Mental Health Film Board film about protective services for the aging has recently become available. Titled "The Rights of Age," it dramatizes the story of one recluse who attempts to be self-sufficient even though she is unable to achieve such an ambition. Twenty or thirty other older people are examined in the 28-minute film, all of whom need either physical, psychological or legal assistance. In black and white, this is an Affiliated Films production, sponsored by the Pennsylvania Department of Public Welfare, Office for the Aging. It is intended for use by all agencies working with older people, health and welfare agencies, schools of social work and nursing, or community groups. Sale price of the Film is \$150 from International Film Bureau, Inc., 332 S. Michigan Ave., Chicago, 60604. Rentals are available from educational film rental sources, or from this agency, at \$7.50.

* * *

The children in a new 21-minute, 16mm. black and white film "To Lighten the Shadows" enjoy new and pleasurable activities in which they are included. They are the mentally retarded, and the brain damage they suffer often prevents development beyond seven to 11-year old levels. Yet they react positively to the warmth and understanding of good supervision. The purpose of the film, produced by Southern Illinois University and the Joseph P. Kennedy Jr. Foundation, is to encourage development of good day camps which further the efforts of the children in growing up to lead independent lives and to cope with the complexities of the world. The unobtrusive eye of the camera catches the reactions of the children in a variety of activities and their responses to fishing, horseback riding, wood gathering, games, songs, contests and handicrafts. The intense expressions of excitement, impatience and suspense on the faces of the children are especially indicative of a process of learning and mental growth taking place. Cooperating in producing the film were the Vocational Rehabilitation Administration of the U. S. Department of Health Education and Welfare, and the Egyptian Association for Mentally Retarded Children (Illinois). The film may be bought for \$125 or rented for \$5 from the International Film Bureau, Inc., 332 S. Michigan Ave., Chicago 60604.



THE DOCTOR'S LIBRARY

POSTMORTEM EXAMINATION Specific Methods and Procedures, Roger D. Baker, M.D., 183 pages, 109 illustrations. W. B. Saunders Company, 1967.

This book prepared by Dr. Baker is intended for pathologists and residents in pathology and reflects the vast experience of the author as a teacher of the subject. This is noted in his attention to details which would have been missed ordinarily by a resident in training.

The book is divided into 13 chapters dealing with such subjects as the medico-legal aspects of an autopsy permit, the performance of an autopsy on a baby as well

as on an adult, the preparation of the autopsy protocol and a provisional diagnoses sheet, the cutting of blocks for microscopic examination, gross and microscopic conferences, techniques in tissue staining, photography and microbiology, the use of autopsy materials for demonstration, the preparation of an autopsy suite and an appendix of weights and measures. The schematic diagrams as well as the illustrations are well chosen and aid the reader in understanding the dissection.

This is an indispensable volume in the library of any department of pathology that has a training program for residents. Paul B. Putong, M. D.

University of Illinois Reports Enrollment Increase of 6%

A total of 2,568 students—1,961 men and 607 women were registered for the winter quarter, 1968, at the University of Illinois Medical Center Campus in Chicago.

According to Dr. Anthony J. Diekema, director of admissions and records, the total is a 6 percent gain, which amounts to an additional 146 students as compared to the same period last year.

Largest enrollment was in the College of Medicine, reporting 816 students registered, followed by the College of Pharmacy with 539, the College of Dentistry with 383 (of which 26 were dental assisting students), the Graduate College 359, (of which 33 were duplicates registered in other curriculums and six were registered with the Chicago Circle Campus), and the College of Nursing, 237.

Postgraduates number 274 (of which 256 were interns and residents in the University's Research and Educational Hospitals.

Following is a breakdown of the College of Medicine:

COLLEGE OF MEDICINE

	Men	Women	Total
First Year Class	179	20	199
Second Year Class	181	14	195
Third Year Class	166	14	180
Fourth Year Class	168	19	187
Total	694	67	761
School of Associated			
Medical Sciences			
Medical Art	3	5	8
Medical Record Administration	0	14	14
Medical Technology	2	11	13
Occupational Therapy	1	19	20
Total	6	49	55

Northwestern Given Grant for Pancreas Transplants

A program of experimental transplantation of the pancreas that may point the way to a surgical cure for diabetes is being intensified at Northwestern University Medical School with an \$86,000 two-year grant from The John A. Hartford Foundation, Inc., of New York City.

Under the grant, announced jointly by Ralph W. Burger, foundation president, and Payson S. Wild, Northwestern vice president and dean of faculties, all aspects of the behavior of the grafted pancreas will be studied.

Leading the research team is Dr. John J. Bergan, assistant professor of surgery. Dr. Bergan pointed out that much information has yet to be gathered on the functioning of a transplanted pancreas, the multi-purpose gland that feeds a digestive

juice into the small intestine and controls blood sugar levels by releasing the hormone, insulin, into the blood stream.

Successful human pancreas transplantation may be near, Dr. Bergan believes, but many problems have yet to be overcome.

"When tissue matching is more accurate, when organs can be reliably stored for at least 24 hours, and when safe methods for offsetting the body's normal rejection response to organ implants are developed, pancreas grafting will undoubtedly be possible," he said.

"All of these requirements now appear to be almost within reach; but even more importantly, basic information will then become available from these transplants which will allow deeper understanding of diabetes."

ISMS LOSES TWO PAST PRESIDENTS



Raleigh C. Oldfield, Sr., M.D., past-president of the Illinois State Medical Society, died Feb. 28 at the age of 75. He was president in 1958-59 and had served as staff president at West Suburban Hospital, alternate delegate to the AMA and councilor from the Aux Plaines Branch of CMS. He was a member of the Fifty Year Club.



Irving H. Neece, M.D., ISMS president in 1947, died March 26 at the age of 85. He had retired from his practice as a urologist in 1964 after 53 years in the field. He was a member of the Fifty Year Club, and had served as president of the Macon County Medical Society and of the staff of Macon County General Hospital.

☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆

☆ ISMS Public Affairs Committee will sponsor a ☆

☆ **Public Affairs Dinner** ☆

☆ **at the** ☆

☆ Illinois State Medical Society Annual Meeting ☆

☆ **Featuring** ☆

☆ **U. S. Senator** ☆
☆ **George Murphy** ☆

☆ **May 20** ☆

☆ **Sherman House — Chicago** ☆

☆ **6:00 p.m.—Reception** ☆

☆ **7:00 p.m.—Dinner** ☆

☆ **Bal Tabarin** ☆



☆ **PLAN TO ATTEND** ☆
☆ **THIS EXCITING PROGRAM!** ☆



Delegates Handbook

**128th Annual Convention,
Illinois State Medical Society
May 19-22, 1968
Sherman House—Chicago**

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Members Of The 1968 House Of Delegates

OFFICERS

President Newton DuPuy
 President Elect.....Philip G. Thomsen
 1st Vice President.....George B. Callahan
 2nd Vice President.....Harold A. Sofield
 Secretary-Treasurer.....Jacob E. Reisch
 Speaker.....Maurice M. Hoeltgen
 Vice Speaker.....Paul W. Sunderland
 (When presiding)

BOARD OF TRUSTEES

First District.....	Carl E. Clark	Fifth District.....	Darrell H. Trumpe
Second District.....	George E. Giffin	Sixth District.....	Mather Pfeiffenberger
Third District		Seventh District.....	Arthur F. Goodyear
William E. Adams	Frank J. Jirka	Eighth District.....	William H. Schowengerdt
J. Ernest Breed	William M. Lees	Ninth District.....	Charles K. Wells
James B. Hartney	Warren W. Young	Tenth District.....	Willard C. Scrivner
Fourth District.....	Paul P. Youngberg	Eleventh District.....	Joseph R. O'Donnell
		Trustee-at-Large.....	Caesar Portes

EX OFFICIO

(Privilege of floor but without the right to vote)

PAST PRESIDENTS

Everett P. Coleman.....1945-1946
 Harlan English.....1964
 Rolland L. Green.....1937
 Edwin S. Hamilton.....1962
 H. Close Hesseltine.....1961
 James H. Hutton.....1940
 Willis I. Lewis.....1954
 George F. Lull.....1963
 Burtis E. Montgomery.....1966
 Edward A. Piszczek.....1965
 Leo P. A. Sweeney.....1953
 Arkell M. Vaughn.....1955

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Walter C. Bornemeier (duplicate—Officer of the
AMA)
 Edward W. Cannady
 Harlan English (duplicate—Past President)
 William K. Ford
 Frank H. Fowler
 Arthur F. Goodyear (duplicate—Trustee 7th
District)
 H. Close Hesseltine (duplicate—Past President)
 Maurice M. Hoeltgen (duplicate—Speaker, ISMS
House)
 Jacob E. Reisch (duplicate—Secretary-Treasurer)
 H. Kenneth Scatliff
 Leo P. A. Sweeney (duplicate—Past President)

PAST TRUSTEES

Earl H. Blair, Chicago (Councilor for the 3rd
District)
 Walter C. Bornemeier, Chicago (Councilor for the
3rd District)
 Fred C. Endres, Peoria (Trustee of the 4th District)
 Willard W. Fullerton, Sparta (Trustee of the 10th
District)
 Lee N. Hamm, Lincoln (Trustee of the 5th District)
 George A. Hellmuth, Chicago (Councilor of the 3rd
District (now living in Wisconsin)
 Bernard Klein, Joliet (Trustee of the 11th District)
 Charles O. Lane, West Frankfort (Councilor of the
9th District)
 Ted Le Boy, Chicago (Trustee of the 3rd district)
 Warner H. Newcomb, Jacksonville (Councilor of the
6th District)
 G. C. Otrich, Belleville (Councilor of the 10th
District)

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION

Walter C. Bornemeier,
 Speaker of the House of Delegates
 (also a member of the Illinois Delegation)
 Burtis E. Montgomery,
 Member of the Board of Trustees
 (Also a past president of Illinois State Medical
Society)

CHICAGO MEDICAL SOCIETY DELEGATES AND ALTERNATES

<i>Delegates</i>	<i>Alternate Delegates</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
AUX PLAINES BRANCH		NORTH SHORE BRANCH	
John S. Hyde	George Chobot	Chester L. Crean	H. K. Scatliff
C. Otis Smith	Chester Thrift	Philip R. McGuire	Robert J. Jensik
William Ashley	Everett Nicholas	Herschel Browns	Eugene J. Ranke
Charles J. Weigel	Michael J. Parenti	Wm. B. Stromberg, Sr.	John B. Murphy
	A. Everett Joslyn Jr.	Willis Diffenbaugh	Samuel T. Gerber
Arthur Gene Lawrence	Roland Kowal	Joseph R. DeCaro	Frank M. Quinn
Joseph C. Sodaro	Gustav Hemwall	William O. Ackley	David T. Petty
Clair M. Carey	Craig D. Butler	Philip M. Bedessem	George C. Markoutsas
		George H. Irwin	Rocco V. Lobraico
		Burton J. Soboroff	Kenneth Penhale
		Clarence A. Norberg	Joseph H. Skom
CALUMET BRANCH		NORTH SIDE BRANCH	
Eugene F. Diamond	Thaddeus C. Fial	Vincent C. Freda	Richard Perritt
Stanley E. Ruzich	Paul Blackburn	Jack Williams	Benjamin F. Lounsbury
Robert E. Lee	Nestor S. Martinez	Erwin M. Patlak	Gutav L. Kaufmann
DOUGLAS PARK BRANCH		Clifton L. Reeder	Joseph Schifano
Edward A. Razim	Arthur F. Reimann	James P. Fitz Gibbons	Lydia Nikurs
Colman J. O'Neill	Robert F. Cesafsky	Michael H. Boley	Joseph C. Sherrick
L. S. Tichy	Paul Zettas	Roland R. Cross	Daniel Ruge
John D. McCarthy	Gilbert R. DeMange	Samuel L. Andelman	Samuel A. Levinson
Raymond Nemecek	Miles Cermak	William A. Hutchison	Bernard T. Peele
		Coye C. Mason	Vitold R. Silins
ENGLEWOOD BRANCH		NORTHWEST BRANCH	
M. Gino	S. Hamilton	I. P. Lombardo	J. M. Smialek
Edward Krol	John Krolkowski	Alfred A. Zanette	Louis A. Wajay
F. Kwin	Joseph Patka	Richard V. Kochanski	
F. Saletta	Kosme Kapov	N. J. Kupferberg	Alexander Reynarowych
William Nainis	John Meyer	Michael J. Kutza	M. A. Rydelski
NORTH SUBURBAN BRANCH		SOUTH CHICAGO BRANCH	
Arnold L. Wagner	Stanley E. Huff	John M. Coleman	Arne Schairer
William G. Cummings	Harold G. Wedell	Casper M. Epsteen	Tibor Czeisler
Frank W. Pirruccello	Martin M. Fahey	Morris T. Friedell	William J. Marshall
Raymond H. Conley	Jerome T. Paul	Simon Y. Saltman	Maynard I. Shapiro
William J. FitzPatrick	John W. O'Donnell		
Howard C. Burkhead	Billy D. Reeves		
Harold Lueth	Willard A. Fry		
C. Malcolm Rice Jr.	James W. Ford		
John L. Savage	Arthur R. Crampton		
William H. Harridge	James R. Dillon		
IRVING PARK SUBURBAN BRANCH		SOUTH SIDE BRANCH	
George Holmes	Vincent Sarley	Alfred S. Klinger	Solomon Green
Eugene Broccolo	Sanford Franzblau	Quentin Young	Jacob M. Epstein
David Dale	Kenneth Maier	Robert R. Mustell	Maurice Gleason
Eugene Narsete	H. Paul Carstens		
Allen Hrejsa	Alexander Ruggie		
George C. Turner	Justin Fleischmann		
Arthur T. Haebich	Frank J. Haufe		
Thomas J. Conley, Jr.	Philip H. Heller		
Alfred J. Faber	M. P. Meisenheimer, III		
JACKSON PARK BRANCH		SOUTHERN COOK COUNTY BRANCH	
Wright R. Adams	Julius E. Ginsberg	Frederick Weiss	C. R. Heidenreich
Andrew J. Brislen	Chester C. Guy	Robert Van Etten	Hyman Love
William J. Hand	Henrietta Herbolsheimer	Cyril Gallati	Gerard Gnade
David S. Fox	Harry L. Hunter		
Loran H. Dill	Daniel J. Pachman		
Charles P. McCartney	Myron M. Hipskind		
		STOCK YARDS BRANCH	
		Edwin J. Lukaszewski	Joseph M. Ruda
		Glenn A. Burckart	Frank J. Nowak
		WEST SIDE BRANCH	
		Eugene T. Hoban	George Rezek
		Anna Marcus	Louis S. Varzino
		AT-LARGE	
		Ralph E. Dolkart	
		Noel G. Shaw	
		Harold A. Sofield	
		Fred A. Tworoger	
		Francis W. Young	
		Warren W. Young	

DOWNSTATE DELEGATES AND ALTERNATES

<i>Delegates</i>	<i>Alternate Delegates</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
ADAMS COUNTY—6th District		JACKSON COUNTY—10th District	
Richard R. Cooper	Harold Swanberg	Leo J. Brown	Robert W. Malony
ALEXANDER COUNTY—10th District		JASPER COUNTY—8th District	
Howard D. Stuckey	Charles L. Yarbrough	Don Hartrick	C. O. Absher
BOND COUNTY—7th District		JEFFERSON-HAMILTON COUNTY—9th District	
Boyd McCracken	Max Fraenkel	D. E. Mitchell	
BOONE COUNTY—1st District		JERSEY -CALHOUN COUNTY—6th District	
John H. Steinkamp	M. Paul Dommers	Bernard Baalman	Samuel Miller
BUREAU COUNTY—2nd District		JO DAVIES COUNTY—1st District	
W. E. Erkonen		C. George Ward	J. Eric Gustafson
CARROLL COUNTY—1st District		KANE COUNTY—1st District	
Lemuel B. Hussey	Wilhelm Jawurek	Wayne N. Leimbach	John Abell
CASS-BROWN COUNTY—6th District		Ben Shirer	Joseph Bordenave
Bruno DeSulis	James J. Hea	Donald Schleifer	Richard Powers
CHAMPAIGN COUNTY—8th District		KANKAKEE COUNTY—11th District	
Clarence H. Walton	H. J. Kolb	Dale M. Learned	H. P. Swartz
Richard E. Schaede	Homer Hindman Jr.	KENDALL COUNTY—11th District	
CHRISTIAN COUNTY—7th District		W. H. Brill	Victor Smith
R. B. Siegert	R. M. Seaton	KNOX COUNTY—4th District	
CLARK COUNTY—8th District		John J. Holland	H. L. Fleisher
E. P. Johnson	George T. Mitchell	LAKE COUNTY—1st District	
CLAY COUNTY—7th District		Donald C. Nellins	John J. Ring
Lucius Hutchens		Charles U. Culmer	John W. Andrews
CLINTON COUNTY—7st District		Earl V. Klaren	Eugene Pitts
Wilson L. DuComb	F. H. Ketterer	LASALLE COUNTY—2nd District	
COLES-CUMBERLAND COUNTY—8th District		James B. Aplington	
Joseph R. Mallory	Mack W. Hollowell	LAWRENCE COUNTY—8th District	
CRAWFORD COUNTY—8th District		Tom Kirkwood	Gilbert Miller
C. N. Salesman	John W. Long	LEE COUNTY—2nd District	
DEKALB COUNTY—1st District		William A. McNichols	
John W. Ovitz	Gordon C. Graham	LIVINGSTON COUNTY—2nd District	
DEWITT COUNTY—5th District		Don L. Ervin	
George Castroville	Herman L. Meltzer	LOGAN COUNTY—5th District	
DOUGLAS COUNTY—8th District		G. E. Tomlinson	W. J. Schall
Walter G. Steiner	James Taylor	MCDONOUGH COUNTY—4th District	
DUPAGE COUNTY—11th District		Donald H. Dexter	V. B. Adams
Morgan M. Meyer	Arthur P. LeBeau	McHENRY COUNTY—1st District	
James P. Campbell	F. C. Kuharich	William J. Marinis	
J. P. Schweitzer	B. L. Rodkinson	MCLEAN COUNTY—5th District	
William E. Hill	Ralph Ryan	L. T. Fruin	Paul Theobald
EDGAR COUNTY—8th District		MACON COUNTY—7th District	
J. M. Ingalls	Joseph R. Shackelford	Maurice D. Murfin	Clarence G. Glenn
EDWARDS COUNTY—9th District		C. Elliott Bell	Carl L. Sandburg
Andrew Krajec	Paul S. Neirenberg	MACOUPIN COUNTY—6th District	
EFFINGHAM COUNTY—7th District		Joseph J. Grandone	William W. Lusk
Peter C. Rumore	Henry J. Poterucha	MADISON COUNTY—6th District	
FAYETTE COUNTY—7th District		W. W. Bowers	Ben B. Berman
Stanley Moore	Mark Greer	E. K. DuVivier	James Adams
FORD COUNTY—11th District		MARION COUNTY—7th District	
Paul W. Sunderland	Ross Hutchison	Karl D. Venters	Walter P. Plassman
FRANKLIN COUNTY—9th District		MASON COUNTY—5th District	
D. L. Griffin	C. E. Ahlm	Jack Means	Dario Landazuri
FULTON COUNTY—4th District		MASSAC COUNTY—9th District	
Keith H. Frankhauser	P. D. Reinertsen	George Green	
GALLATIN COUNTY—9th District		MENARD COUNTY—5th District	
John E. Doyle	Joseph Bryant	Robert Schafer	Barry D. Free
GREENE COUNTY—6th District		MERCER COUNTY—4th District	
Paul A. Dailey	Arthur K. Baldwin	Martin E. Conway	Monty P. McClellan
HANCOCK COUNTY—4th District		MONROE COUNTY—10th District	
Byron T. Mueller	Christian Wm. Bruchsel	Joseph A. Werth	Edilberto F. Maglasang
HENDERSON COUNTY—4th District		MONTGOMERY COUNTY—5th District	
Harold L. Bock	Silvino Lindo Jr.	Vincent J. Parlente	
HENRY-STARK COUNTY—4th District		MORGAN COUNTY—6th District	
Paul M. Schmidt	William D. Larson	Robert R. Hartman	Ernst C. Bone
IROQUOIS COUNTY—11th District		OGLE COUNTY—1st District	
R. Kent Swedlund	James E. Dailey	Russell W. Zack	A. R. Bogue

*Delegates**Alternate Delegates*

PEORIA COUNTY—4th District
 William O. McQuiston G. W. Giebelhausen
 Clarence V. Ward H. Sargent Howard
 Fred Z. White George J. Best

PERRY COUNTY—10th District
 C. E. Cawvey James B. Stotlar

PIATT COUNTY—7th District
 A. O. Trimmer W. E. Mundt

PIKE COUNTY—6th District
 Myer Shulman Gene Goodman

PULASKI COUNTY—10th District
 A. L. Robinson

RANDOLPH COUNTY—10th District
 O. W. Pflasterer Louis Mattingly

RICHLAND COUNTY—8th District
 Charles DeKovessey William A. Moore

ROCK ISLAND COUNTY—4th District
 Theodore Grevas C. S. Costigan
 C. P. Cunningham John C. Rathe

ST. CLAIR COUNTY—10th District
 William Walton Lloyd Walk
 V. P. Siegel Harold McCann

SALINE-POPE-HARDIN COUNTY—9th District
 John R. Duffey D. A. Lehman

SANGAMON COUNTY—5th District
 Preston V. Dilts Floyd S. Barringer
 Chauncey C. Maher Jr. Earl W. Donelan
 A. R. Eveloff Ross Schlich

SCHUYLER COUNTY—4th District
 Henry C. Zingher Rosemary Utter

SHELBY COUNTY—7th District
 Richard Larson Otto Kander

*Delegates**Alternate Delegates*

STEPHENSON COUNTY—1st District
 Thomas A. Haymond Eugene Vickery

TAZEWELL COUNTY—5th District
 Rudolph A. Helden Adam Slaw

UNION COUNTY—10th District
 William H. Whiting

VERMILION COUNTY—8th District
 E. G. Andracki T. E. Pollard

WABASH COUNTY—9th District
 Roger I. Fuller R. A. Richey

WARREN COUNTY—4th District
 Richard Icenogle Russell Jensen

WASHINGTON COUNTY—10th District
 Jerry L. Beguelin

WAYNE COUNTY—9th District
 Charles J. Jannings Edward S. Talaga

WHITE COUNTY—9th District
 P. D. Boren J. A. Stricklin

WHITESIDE COUNTY—2nd District
 Clarence J. Mueller

WILL-GRUNDY COUNTY—11th District
 Bruce J. Wallin Franklin K. Bowser
 Barry S. Seng F. Roger Fahrner
 Robert J. Becker James H. Lambert

WILLIAMSON COUNTY—9th District
 Herbert V. Fine

WINNEBAGO COUNTY—1st District
 F. A. Munsey
 L. P. Johnson Robert E. Heercns
 Harold E. Zenisek E. T. Leonard
 H. E. LaPlante F. H. Riordan III

WOODFORD COUNTY—2nd District
 R. J. Davies J. C. Phifer

Agenda for The 1968 Meeting of The House of Delegates

MAURICE M. HOELTGEN, *speaker*
 PAUL W. SUNDERLAND, *vice speaker*

FIRST SESSION

3 p.m. Sunday, May 19, 1968

The Executive Ballroom, Sherman House, Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen
2. Invocation
3. Roll Call
Report of the Committee on Credentials
4. Report of the Committee on Rules & Order of Business
5. Approval of the minutes of the May, 1967, meeting of the House of Delegates
6. Remarks of the Speaker
Maurice M. Hoeltgen
7. Memorial service for members of ISMS who have died since May, 1967
Jacob E. Reisch, *Secretary*
8. Introduction of representative of the STUDENT AMERICAN MEDICAL ASSOCIATION, Joseph Valaitis, Jr., and students from SAMA chapters at Chicago Medical School; Northwestern University Medical School; Stritch School of Medicine; University of Illinois College of Medicine & University of Chicago Medical School
9. Introduction of representative of Illinois Chapter AMERICAN MEDICAL ASSISTANTS ASSOCIATION, Mrs. Helen Smith
10. Special report to the House
Mrs. Mitchell Spellberg, *President*, Woman's Auxiliary Illinois State Medical Society

11. Introduction of officers of other state medical societies and honored guests:
Newton DuPuy, *President*
12. Presentation of AMA-ERF checks to the representative of the five Illinois Medical Schools
13. IMPAC (Illinois Medical Political Action Committee) report
Philip G. Thomsen, *Chairman*
14. President's Address:
Newton DuPuy, *President*, Illinois State Medical Society
15. Report to the House
George F. Lull, *Executive Administrator*
16. Presentation of the EDWIN S. HAMILTON TEACHING AWARD of the Interstate Postgraduate Medical Association
To: Arthur R. Colwell, M.D.
By: George F. Lull, MD, *Immediate Past President*, Interstate Post-graduate Medical Association
17. Introduction of supplementary reports
18. Announcement of Reference Committees for 1968 House

- Maurice M. Hoeltgen, *Speaker*
- a. Committee on Credentials
 - b. Committee on Rules and Order of Business
 - c. Sergeants-at-Arms and Tellers
 - d. Reference Committee on Amendments to the Constitution & Bylaws
 - e. Reference Committee on Reports of Officers & Administration
 - f. Reference Committee on Finances & Budgets
 - g. Reference Committee on Economics & Insurance
 - h. Reference Committee on Publications & Scientific Services
 - i. Reference Committee on Legislation & Public Affairs
 - j. Reference Committee on Public Relations & Miscellaneous Business
19. Introduction of resolutions and referral to correct reference committee
Maurice M. Hoeltgen, *Speaker*
 20. New business and announcements
 21. Recess until 2 p.m., Tuesday, May 21, when House will hear the reports of the reference committees.

SECOND SESSION

2 p.m. Tuesday, May 21

The Executive Ballroom, Sherman House, Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen
2. Roll Call
Report of the Committee on Credentials
3. Report of the Committee on Rules & Order of Business
4. Announcement of the recipients of the Scientific Awards
Coye C. Mason, *Director of Scientific Exhibits*
 - a. Introduction of officers of other state medical societies or honored guests:
Newton DuPuy, *President*
 - b. Other
5. Reports of Reference Committees:
 - a. Constitution & Bylaws
 - b. Officers & Administration
 - c. Finances & Budgets
 - d. Economics & Insurance
 - e. Publications & Scientific Services
 - f. Legislation & Public Affairs
 - g. Public Relations & Miscellaneous Business
6. Unfinished business
7. New business
8. Recess until 2 p.m. Wednesday afternoon, May 22

THIRD SESSION

2 p.m. Wednesday, May 22

The Executive Ballroom, Sherman House, Chicago

1. Call to order by the Speaker
Maurice M. Hoeltgen
2. Roll call
Report of Committee on Credentials
3. Report of Committee on Rules & Order of Business
4. Introduction of officers of other state medical societies or honored guests:
Newton DuPuy, *President*
5. Induction of Philip G. Thomsen, *President Elect*, into the office of President of the Illinois State Medical Society
By: Newton DuPuy, *Retiring President*
6. Presentation of remaining Reference Committee reports
7. Elections
Report of the nominating committee:
 - a. President-elect (Downstate)
 - b. First Vice President (CMS)
 - c. Second Vice President (Downstate)
 - d. Secretary-Treasurer (Downstate)
 - e. Speaker of the House (CMS)
 - f. Vice Speaker (Downstate)
 - g. Trustees:

District	Terms Expiring
1st	Carl E. Clark, Sycamore
2nd	George E. Giffin, Princeton, (Unexpired term of Dr. Redmond)
3rd	William M. Lees, Lincolnwood
	Frank J. Jirka, River Forest
11th	Joseph R. O'Donnell, Glen Ellyn
- h. Delegates to the AMA (To take office Jan. 1, 1969, and serve for a term of two years)
Terms expiring: Maurice M. Hoeltgen
Leo P. A. Sweeney
H. Close Hesseltine
William K. Ford
Jacob E. Reich
- i. Alternate Delegates to the AMA (To take office Jan. 1, 1969, and serve for a term of two years)
Terms expiring: Theodore R. Van Dellen
Allison L. Burdick, Sr.
Arkell M. Vaughn
Paul A. Dailey
Fred C. Endres

8. Unfinished business
9. New business
 - a. Fixing of the per capita assessment for 1969
 - b. Selection of the meeting place for 1971
 - c. Election of Emeritus, Retired members and

those whose dues have been cancelled for cause

Jacob E. Reisch, *Secretary*
d. Other

10. Adjournment-sine die

Committees For The 1968 House Of Delegates

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall pass out and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House on Sunday, and one-half hour prior to the opening of the other two sessions.

The present schedule is:

Sunday, May 19	2:00 p.m.
Tuesday, May 21	1:30 p.m.
Wednesday, May 22	1:30 p.m.

L. T. Fruin, <i>Co-Chairman</i>	
Fred A. Tworoger, <i>Co-Chairman</i>	
E. K. DuVivier	F. A. Munsey
Robert R. Mustell	

COMMITTEE ON RULES AND ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close co-operation with the Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

The first meeting of the committee should be scheduled on Sunday morning, May 19, in order to have a report to present as the first report scheduled at the opening session of the House on Sunday afternoon.

Casper Epsteen, <i>Chairman</i>	
Maurice D. Murfin	Clarence A. Norberg
Raymond Nemecek	Harold E. Zenisek

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot vote is scheduled, or the House goes into executive session.

Wayne N. Leimbach, <i>Chairman</i>	
Charles J. Jannings, III	Philip R. McGuire
Edward Krol	William McNichols

REFERENCE COMMITTEE ON REPORTS OF OFFICERS & ADMINISTRATION

7 p.m., Sunday, May 19

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

THE PRESIDENT, Newton DuPuy
THE PRESIDENT-ELECT, Philip G. Thomsen
THE 1ST VICE PRESIDENT, George B. Callahan
THE 2ND VICE PRESIDENT, Harold A. Sofield
THE SECRETARY, Jacob E. Reisch
THE CHAIRMAN OF THE BOARD, Arthur F. Goodyear
THE EXECUTIVE ADMINISTRATOR, George F. Lull
THE TRUSTEES OF THE 11 TRUSTEE DISTRICTS, Carl E. Clark, George E. Giffin, William M. Lees, Warren W. Young, Frank J. Jirka, J. Ernest Breed, William E. Adams, James B. Hartney, Paul P. Youngberg, Darrell H. Trumpe, Mather Pfeifferberger, Arthur F. Goodyear, William H. Schowengerdt, Charles K. Wells, Willard C. Scrivner, Joseph R. O'Donnell
THE TRUSTEE AT LARGE, Caesar Portes
THE SPEAKER OF THE HOUSE OF DELEGATES, Maurice M. Hoeltgen

Polo Room 102

THE VICE SPEAKER OF THE HOUSE OF DELEGATES, Paul W. Sunderland

THE PRESIDENT OF THE WOMAN'S AUXILIARY, Mrs. Mitchell A. Spellberg

THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY, Philip G. Thomsen, *Chairman*

BOARD COMMITTEES:

POLICY COMMITTEE, William E. Adams, *Chairman*
THE COMMITTEE TO STUDY COMMITTEES, William H. Schowengerdt, *Chairman*

THE ETHICAL RELATIONS COMMITTEE, Willard C. Scrivner, *Chairman*

THE COMMITTEE TO CONSIDER OSTEOPATHIC PROBLEMS, William E. Adams, *Chairman*

THE AMA DELEGATION FROM ISMS, Maurice M. Hoeltgen, *Chairman*

C. E. Cawvey, <i>Chairman</i>	
E. G. Andracki	C. Otis Smith
Charles U. Culmer	Alfred A. Zanette

REFERENCE COMMITTEE ON FINANCES & BUDGETS

7 p.m., Sunday, May 19

Jade Room 103

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

THE TREASURER, Jacob E. Reisch

THE BENEVOLENCE COMMITTEE, Keith H. Frankhauser, *Chairman*

THE RURAL HEALTH & STUDENT LOAN FUND COMMITTEE, Jack L. Gibbs, *Chairman*

THE EDUCATIONAL & SCIENTIFIC FOUNDATION, Caesar Portes, *Chairman*

Francis W. Young, *Chairman*

Keith Frankhauser

Stanley Ruzich

William E. Hill

Noel G. Shaw

REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

7 p.m., Sunday, May 19

Gold Room 114

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

(I) COUNCIL ON LEGISLATION & PUBLIC AFFAIRS

COMMITTEE ON LEGISLATION, V. P. Siegel, *Chairman*

COMMITTEE ON PUBLIC AFFAIRS, Theodore Grevas, *Chairman*

COMMITTEE ON EYE HEALTH, James R. Fitzgerald, *Chairman*

(II) ADMINISTRATION

COMMITTEE ON ARCHIVES, Emmet F. Pearson, *Chairman*

(III) JUDICIAL COUNCIL

IMPARTIAL MEDICAL TESTIMONY, Clinton Compere, *Chairman*

COMMITTEE ON QUACKERY, Edward A. Piszczek, *Chairman*

(IV) SCIENTIFIC ADVANCEMENT

NARCOTICS & HAZARDOUS SUBSTANCES, Joseph H. Skom, *Chairman*

Eugene P. Johnson, *Chairman*

Herschel Browns

Alfred J. Faber

Preston V. Dilts

Peter Rumore

REFERENCE COMMITTEE ON CHANGES IN THE CONSTITUTION & BYLAWS

7 p.m., Sunday, May 20

Holiday Room 105

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and/or Bylaws.

COMMITTEE ON CONSTITUTION & BYLAWS, Andrew J. Brislen, *Chairman*

John H. Steinkamp, *Chairman*

C. P. Cunningham

Edwin J. Lukaszewski

William H. Harridge

Glen E. Tomlinson

REFERENCE COMMITTEE ON ECONOMICS & INSURANCE

7 p.m., Sunday, May 19

Old Chicago Room 101

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

(I) COUNCIL ON MEDICAL SERVICE:

COMMITTEE ON PREPAYMENT PLANS, Philip C. Lynch, *Chairman*

COMMITTEE ON MEDICAL ECONOMICS AND INSURANCE, Fred Z. White, *Chairman*

SUB-COMMITTEE ON RELATIVE VALUE, C. Elliott Bell, *Chairman*

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS DEPARTMENT OF PUBLIC AID, Fred A. Tworoger, *Chairman*

SUB-COMMITTEE ON DRUGS AND THERAPEUTICS, Robert C. Muehrcke, *Chairman*

(II) ADMINISTRATION:

COMMITTEE ON USUAL AND CUSTOMARY FEES, Philip G. Thomsen, *Chairman*

DIRECTOR OF THE DEPARTMENT OF PUBLIC AID, Mr. Harold Swank

(III) PUBLIC RELATIONS:

HOSPITAL RELATIONS, J. W. Buser, *Chairman*

Robert J. Becker, *Chairman*

Leo J. Brown

George W. Holmes

Clair M. Carey

R. Keith Swedlund

REFERENCE COMMITTEE ON PUBLICATIONS & SCIENTIFIC SERVICES

7 p.m., Sunday, May 19

Orchid Room 106

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

(I) COUNCIL ON SCIENTIFIC ADVANCEMENT

- COMMITTEE ON ALCOHOLISM, Abraham Gelperin, *Chairman*
- COMMITTEE ON CANCER CONTROL, Thomas Sellett, *Chairman*
- COMMITTEE ON CHILD HEALTH, Ralph H. Kunstadter, *Chairman*
- COMMITTEE ON MATERNAL WELFARE, Robert R. Hartman, *Chairman*
- COMMITTEE ON MENTAL HEALTH, John R. Adams, *Chairman*
- COMMITTEE ON NUTRITION, Paul A. Dailey, *Chairman*
- COMMITTEE ON PUBLIC HEALTH, Thomas P. deGraffenried, *Chairman*
- SUB-COMMITTEE ON ENVIRONMENTAL HEALTH, Clarke W. Mangun, Jr., *Chairman*
- SUB-COMMITTEE ON LABORATORY EVALUATION, Grover L. Seitzinger, *Chairman*
- SUB-COMMITTEE ON OCCUPATIONAL HEALTH, Edward C. Holmblad, *Chairman*
- SUB-COMMITTEE ON TUBERCULOSIS, Charles K. Petter, *Chairman*

COMMITTEE ON RADIATION, Howard C. Burkhead, *Chairman*

COMMITTEE ON REHABILITATION SERVICES, Henry B. Betts, *Chairman*

SPECIAL REPRESENTATIVES

DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC HEALTH, Frank D. Yoder

DIRECTOR, ILLINOIS DEPARTMENT OF MENTAL HEALTH, Harold A. Visotsky

(II) ADMINISTRATION

ILLINOIS MEDICAL JOURNAL

THE EDITOR, T. R. VanDellen

THE EDITORIAL BOARD, Samuel A. Levinson, *Chairman*

THE JOURNAL COMMITTEE, Jacob E. Reisch, *Chairman*

(III) COUNCIL ON MEDICAL EDUCATION

COMMITTEE ON MEDICAL EDUCATION, Morgan M. Meyer, *Chairman*

COMMITTEE ON CONTINUING EDUCATION, Robert J. Freeark, *Chairman*

COMMITTEE ON SCIENTIFIC ASSEMBLY, Robert T. Fox, *Chairman*

That portion of the report on the COMMITTEE ON RURAL HEALTH & STUDENT LOAN which pertains to EDUCATION, Jack L. Gibbs, *Chairman*

Charles P. McCartney, *Chairman*

Don L. Ervin

Cyril Gallati

Vincent Freda

Dale M. Learned

REFERENCE COMMITTEE ON PUBLIC RELATIONS & MISCELLANEOUS BUSINESS

7 p.m., Sunday, May 19

Ruby Room 113

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees, and upon any other matters referred to the committee by the Speaker:

(I) COUNCIL ON PUBLIC RELATIONS

- COMMITTEE ON PUBLIC RELATIONS, Matthew B. Eisele, *Chairman*
- PHYSICIANS' PLACEMENT SERVICES
- COMMITTEE ON RELIGION & MEDICINE, Robert S. Mendelsohn, *Chairman*
- COMMITTEE ON MEMBERSHIP, Henry A. Holle, *Chairman*
- COMMITTEE ON DISASTER MEDICAL CARE, Max Klinghoffer, *Chairman*
- SUB-COMMITTEE ON PUBLIC SAFETY, Edwin A. Lee, *Chairman*

Charles J. Weigel, *Chairman*

Eugene Hoban

John J. Holland

ADVISORY TO OTHER PROFESSIONAL GROUPS, James D. Majarakis, *Chairman*

ILLINOIS ASSOCIATION OF THE PROFESSIONS

INTERPROFESSIONAL COUNCIL

THE BAR ASSOCIATION

ADVISORY TO PARAMEDICAL GROUPS, W. I. Taylor, *Chairman*

NURSING, Ted LeBoy, *Chairman*

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION, Thomas R. Harwood, *Chairman*

ADVISORY TO SAMA, Edward J. Krol, *Chairman*

HEALTH CAREERS COUNCIL, Allison L. Burdick, Jr., *Chairman*

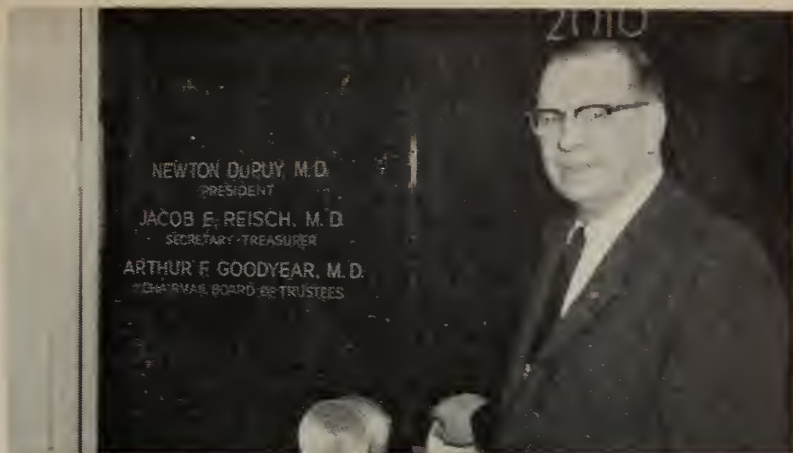
(II) COUNCIL ON MEDICAL SERVICE

COMMITTEE ON AGING, Bertram M. Moss, *Chairman*

Myer Shulman

LEVEL OF THE PRESIDENT'S RESIDING AT THE ANNUAL CONVENTIONS 1897 THROUGH 1961, SINCE 1961 SPEAKERS OF THE HOUSE HAVE BEEN THE RESIDING OFFICERS.

PRESIDENTS	1840 - 1961	
1888	LEWIS C. TAYLOR	1925
1889	JACOB C. KRAFFT	1926
1890	MATHEW PFEIFFENBERGER	1927
1891	G. HENRY MUNDY	1928
1892	JOHN E. TUITE	1929
1893	FREDERICK O. FREDRICKSON	1930
1894	WILLIAM D. CHAPMAN	1931
1895	R. RALPH FERGUSON	1932
1896	JOHN R. NEAL	1933
1897	PHILIP H. KREUSCHER	1934
1898	CHARLES D. CENTER	1935
1899	CHARLES S. SKAGGS	1936
1900	CHARLES B. REED	1937
1901	ROLLAND L. GREEN	1938
1902	ROLLO K. PACKARD	1939
1903	SAMUEL E. MUNSON	1940
1904	JAMES H. HUTTON	1941
1905	JAMES S. TEMPLETON	1942
1906	CHARLES H. PHIFER	1943
1907	EDWARD H. WELD	1944
1908	GEORGE W. POST	
1909	EVERETT	



Officers and Administration

PRESIDENT

As president of the Illinois State Medical Society for 1967-68, I bring you a brief report of my activities and will touch lightly on various subjects. For a more comprehensive review of the year I would refer you to the excellent reports of the Chairman of the Board, the President-Elect, the Executive Administrator, the Secretary-Treasurer, and the several chairmen of the councils. First, I should like to express my appreciation for the privilege of serving as president of the Illinois State Medical Society. It is an honor I shall always cherish. It is an experience I would wish for every physician if that were possible. As others have said, time passes too swiftly to accomplish all the things desired.

The presidency affords a wonderful opportunity to make new friends in Illinois and in the adjoining states. It was my pleasure to attend the following state medical society meetings: Kentucky, Indiana, West Virginia (100th anniversary), and, before my year is out, Iowa, Missouri and Wisconsin. Dr. Lull graciously represented me at the Michigan meeting when a conflict prevented my attendance. I attended the AMA convention in Atlantic City, N.J., and the clinical session of the AMA in Houston, Texas. At the Houston meeting it was my privilege to present the Illinois State Medical Society check for \$165,000 to AMA-ERF in the name of our beloved Percy Hopkins.

Another pleasant trip was taken to New York with the Journal Committee. Let me mention at this point that certainly we have one of the finest medical journals. Mr. Perry Smithers and Mr. John Kinney should be highly commended for the excellent job they are doing. Also, Mr. Smithers has been of invaluable help to me in editing the President's Page.

The visit to Washington, D.C., with the Public Affairs Committee, was an enjoyable and instructive occasion and I would recommend it to every physician. This meeting occurs annually in conjunction with the meetings of the Associations of the U.S. Chamber of Commerce. I attended the American Medical Political Action Committee (AMPAC), which meets annually in the nation's capital, for an intensive and instructive 42 hours. They would find it difficult to teach our Mr. Roger White anything; the Illinois State Medical Society legislative activities are second to no other state. On my visits to the legislature I have never heard anything but praise for Mr. White. Finally, there is the National Chamber of Commerce annual meeting in late April in Washington, D.C., with the opportunity of visiting again with the Senators and Congressmen from Illinois. So much for the out-of-state wanderings.

Early in this presidential year, Mr. James Slawny, Director of Public Relations of the Illinois State Medical Society, conceived the idea of "The President's Tour" to all areas of our state. It was a staggering load for Mr. Slawny and his department to assume, but he has carried it out superbly and he

kept the President-Elect, Dr. Thomsen, and me on the go. Let me say that we could not have accomplished one-half as much without the help of Dr. Thomsen.

Whenever I have been in the headquarters office, or whenever I needed information regarding the financial or business affairs of the State Society, Mr. Roland King has been most co-operative and has provided me with every assistance. He is an asset to our staff.

The duties of the president require that, among other things, he be the State Society's representative at numerous functions. In that capacity I attended many meetings in all parts of the state. Just to mention a few, these included: American College of Radiology, American Association of Medical Clinics, American Medical Writers' Association, Clinical Congress of Abdominal Surgeons, Illinois Welfare Council, Illinois Public Health Association, Illinois Medical Assistants Association, Illinois Veterinary Association, University of Health Services (Chicago Medical School), University Health Services (Champaign), Health Improvement Association, and Illinois Hospital Association. Your president, by directive of Governor Kerner, serves on the Illinois Hospital Licensing Board. I also attended the meeting of the Illinois Association of the Professions. This is an organization that deserves your support and I hope you will join. Professional men should band and stand together to uphold the dignity of the professions.

Health manpower shortage is currently a concern of state and national importance. The AMA has selected your president to serve on its committee which is considering the problem. It is an established fact that for each physician, 13 individuals serve on the health team and it is estimated that by 1970 this will increase to 17. The public should be educated to understand that the rising cost of medical care is due to its increasing demands for service and not to the physician's charges alone.

We must be constantly on the alert to restrain the social planners who are desirous of expanding medicare and I urge you to carefully study the publications of your society to keep abreast of these issues. I am not satisfied that I have sufficiently stimulated our membership from the lethargy that has plagued us for so long a time. In the interest of answering unjust criticism of the medical profession, we must vigorously continue our public relations programs to educate the public. I sincerely believe that education can solve all problems.

On the bright side I can call to your attention the fact that all agencies are now paying usual and customary fees. For emphasis, I shall list them: Illinois Department of Public Aid, the Department of Vocational Rehabilitation, Medicare, Medicaid and Blue Shield. This has been a long and arduous fight and full credit should go to all the members of the various committees who have served over the last several years. Perhaps at this point I should mention the friendly rapport that exists with IDPA due to the splendid co-operation of the Director, Mr. Swank, and the Medical Director, Dr. Holle. In the first 11 months of 1966, over \$5,000,000 was paid the doctors of Illinois. In the first 11 months of 1967, \$9,800,000 was paid the doctors of Illinois.

I should like to pay a tribute to Dr. Franklin Yoder for the efficient manner in which he conducts the

Department of Public Health and for his continued close co-operation with the Illinois State Medical Society. His presence at our board meetings is always welcome. For the same reason, Dr. Visotsky, of the Department of Mental Health, should also be complimented. However, we do not see him often enough at our board meetings.

We have strong friendships in the legislature in Springfield and we have always received from Governor Kerner the most courteous and sympathetic attention to our problems. In my book he has the highest rating. We can only hope that his successor will be as well qualified.

As your president, this year has been a most happy one in spite of a little frustration at not being able to accomplish all that I had planned. I very much enjoyed the "President's Tour" and greatly appreciate the many courtesies extended to me and your warm hospitality. Illinois medicine can be grateful that we have so many dedicated physicians who are willing to make personal sacrifices for the good of the profession. May I express my thanks to the President's Advisory Committee, the officers, and the trustees for their perfect co-operation. My sincere thanks are given to the members of the Woman's Auxiliary who do such a tremendous job and receive so little credit. Their program includes such worthwhile projects as legislation, paramedical recruitment, community service, international health activities, Benevolence, and AMA-ERF. The Woman's Auxiliary is without doubt medicine's staunchest ally and deserves your full support.

My report would not be complete if I did not commend each member of our staff. Their loyalty and devotion is something of which we can all be proud. Mrs. Frances Zimmer answered all my questions and kept me on schedule. We should further impose on her to supervise the editing of Volume III of "The History of Medical Practice in Illinois."

I am sure I speak for the entire membership when I express to Dr. Lull our warmest thanks for again coming to the rescue as executive administrator. You are all familiar with our past president's distinguished career. You would wish me to pay him the highest compliment, and that is to say that he is the perfect gentleman.

To you Dr. Lull, to you:

A health to you and wealth to you

And the best that life can give to you.

May fortune still be kind to you,

And happiness be true to you,

And life be long and good to you

Is the toast of all your friends to you.

Newton DuPuy

PRESIDENT-ELECT

During the past year, the president-elect of your Illinois State Medical Society was extremely busy addressing physicians, medical assistants and the lay public on: (1) The President's Tour; (2) The Annual Blue Shield Meetings for Medical Assistants; and (3) as an ISMS spokesman on radio-TV and in the press.

President's Tour—This program—launched last fall to improve communications with our grass roots members, county society officers and community leaders—took your president-elect to seven counties where he addressed some 500 physicians, 500 community leaders and did numerous radio, TV and

press interviews. Cities visited included: Rock Island, Moline, East St. Louis, Alton, Decatur, Waukegan, Springfield and Elgin.

I addressed physicians on Problems with Usual and Customary Fees, The Need for a Medical Review Board, and The Corporate Practice of Medicine. To community leaders, we addressed ourselves to the problem of Physician Shortage, Quackery, and The Changing Face of Medicine. As arduous as The President's Tour is, it proved extremely successful and I look forward to participating again next fall.

Medical Assistants Meetings—To help medical assistants understand the ISMS philosophy on usual and customary fees, your president-elect addressed four large Blue Shield Meetings for Medical Assistants. The meetings were held before 1,200 medical assistants in DuPage County, Will County, North Chicago and South Chicago.

Radio, TV, Press—We also appeared on numerous radio and television programs throughout the state. No matter where we traveled, we found the press, radio and TV to be very cooperative and sympathetic to the problems of the medical profession. I hope we can continue our good relations with the press for never before has medicine needed the support of the mass media as we do today.

Other Meetings—In addition, your president-elect addressed: the Southern Illinois Medical Society Nov. 9; the Blue Shield-ISMS Medicare Conference, Chicago, March 17; Fifth District Meeting, Springfield, March 21; and the ISMS Leadership Conference in Springfield April 7.

I also attended: the ISMS Public Affairs Workshop Nov. 5; the AMA meeting in Houston Nov. 27-30; the Medicare Utilization Review Conference Jan. 10; ISMS Public Affairs Workshop in Washington, D.C., Jan. 30; AMPAC Workshop in Washington, D.C., March 9-10; the U.S. Chamber of Commerce meeting, Washington, D.C., April 28-30; all ISMS executive committee and Board of Trustees meetings during the year.

While the past 12 months have been very busy, they have also proved most rewarding. In conclusion, I would like to thank President Dr. Newton DuPuy, the Board of Trustees, the officers and staff for their cooperation.

Philip G. Thomsen

FIRST VICE PRESIDENT

To travel is to know man. My first duty as vice president was to travel to Decatur in lieu of the president and there to know and to address many pharmaceutical friends and be hosted by our genial Chairman of the Board, Dr. Arthur F. Goodyear.

Later I was privileged to travel and represent the American Medical Association in World Congresses of medical law (Ghent, Belgium); International Surgeons Society (Vienna, Austria); two on Gynecology (Tehran, Iran) and the Federation of International Gynecologists and Obstetricians (Sydney, Australia). The fifth major stop for conference was in Bangkok. In each of these my official greetings were written on ISMS letterheads and references were made to Illinois and Lake County as components of our great national organization, the American Medical Association.

Thus, regarding American medicine, wherever a

lecture or convention (on a topic of Siamese Twins) permitted, I have tried to be a scientist as best defined by a professor of biology who replied to a somewhat aggressive district attorney. After a series of questions he finally asked, "Professor, just what is a scientist?" The professor replied, "Well Sir, a scientist is one who seeks the truth and, having found it, shares it with others. That is what I have tried to do with you today."

It is this esteemed truth about American medicine that I have tried, in my small way, to tell to man and his world. I have found our medical colleagues across the world with similar cordial beliefs.

I thank you for the privilege of participating as your 1st Vice President this past year.

George B. Callahan

SECOND VICE PRESIDENT

The position of 2nd vice president is undoubtedly an emergency type of office, and fortunately no emergencies arose during the past year.

Most of my activity having to do with the Illinois State Medical Society resulted from two appointments by the Governor.

I have been and continue to serve on the Governor's Commission for the Study of the Public Health needs of the State of Illinois, and also on the Governor's Committee on Heart, Cancer and Stroke (now called the Regional Medical Program).

As a member of the Public Health Commission, we have held monthly meetings, mostly at the Chicago Board of Health, or at the State of Illinois Building in Chicago. Only two meetings were held in Springfield. A number of recommendations were made to the Governor and a number of bills having to do with public health projects, either presently functioning or deemed by the commission to be desirable, were introduced in the legislature. Several of the bills were passed.

The commission has been reappointed after having served its first two years, and at the present time Senator Robert Coulson is chairman and I am serving as treasurer. Meetings will be continued at monthly intervals. At the next meeting two of the deans of the medical schools in Chicago, as well as the Director of the Illinois Regional Medical Program (Wright Adams), will speak.

The work on the Heart, Cancer and Stroke Commission has included the formulation of a plan accepted by the authorities in Washington which is now being detailed by various task forces. Dr. Adams is the executive of this commission and its work is state-wide and may overlap into adjoining states. The work of the Regional Program will take considerable time to get under way, but satisfactory progress seems evident.

In addition to serving on these two commissions, I have been asked to substitute for the president-elect, Dr. Philip Thomsen at a meeting of the group being organized to activate the Comprehensive Health Plan for the state of Illinois. I have also attended meetings of the Committee on Legislation of the state society, by invitation.

Harold A. Sofield

SECRETARY-TREASURER

The report of the secretary-treasurer will be found under Finances and Budgets, page 459.

FIRST DISTRICT

Attendance at the county medical society level needs stimulation. An indifferent and uninformed membership is directly proportional to the lack of attendance of the members at society meetings. Failure of the officers and committee chairmen to avail themselves of information seminars and leadership training opportunities, provided by organized medicine, compounds the problem.

Support of our medical allies needs a more positive approach. Encouragement, by the House of Delegates, in these matters should stimulate correction. The physician is becoming a victim of many forces which are attempting to fence him in. Those in government, who wish to dictate and organize his professional, as well as economic activities, are aided by the public—a public rapidly being anesthetized in the joys of give-away medicine. All this behooves the doctor to keep a local medical society strong and to be currently aware of what goes on. Too many of our county societies meet irregularly. Frequency is not as important as regularity. Officers and committee chairmen do not take advantage of leadership training opportunities offered by the AMA and ISMS. Poor leadership compromises the desire for membership participation. Each society needs to evaluate its attendance and leadership problems in order to be more effective in guiding the destinies of medicine and the impact upon the individual physician.

The tendency for an increasing number of societies, both large and small, to operate by executive committee or council, carries the danger of "concealed rule by a few," with suppression of democratic procedures.

With the many forces bearing down on the fate of the physician and with the ever increasing workload of all physicians, it becomes more necessary to have understanding, loyal and well trained assistants. Physician support of various educational organizations of technicians and medical assistants is desirable. Dr. Milford Rouse, President of AMA, in his talk to the AMA House of Delegates, suggested that physicians should encourage these programs. The local county medical assistants association has a valuable educational program and, if a medical assistants group is not organized in a county, the physicians should lead in its formation. Technicians, nurses and all other paramedical people should be aided in their progress for improvement of their skills. Allowing these assistants paid time to attend conventions and seminars will reward the physicians, greatly. Many physicians subsidize their dues.

Routinely, the chores of the First District Trustee were not different than in previous years. Meetings as the guest of the societies have always been hospitable and cordial and it is a distinct pleasure to be their guest. I have been privileged to present 50-Year membership plaques to several doctors. One rather serious grievance was carried to the district level and referred to the ISMS Grievance Committee.

I wish to thank all officers and members of the societies of the First District for their support and co-operation. It has been a pleasure to serve in this capacity.

Carl E. Clark, *Trustee*

SECOND DISTRICT

The component societies of the Second District have continued to hold regular meetings and various members have participated in and contributed to meetings of local and regional interest.

There have been no specific problems brought to the attention of your trustee during this year. All secretaries or delegates in the district have been contacted on two or more occasions to elicit information and invite attention to the available assistance and information provided by the State Society.

Your trustee has participated in two committees: an informal meeting for exchange of ideas with the members of the Illinois Osteopathic Association and an operational and organizational study of the Headquarters of the Illinois State Medical Society. Both meetings were held in Chicago.

Industrial developments of considerable magnitude at Hennepin, by Jones & Langhlin Steel Corp., is bringing rapid population changes thus creating unusual challenges to the medical field. These are being met by expanding facilities and the co-operation of all medical personnel in the surrounding communities.

It is my pleasure to report that Dr. Ralph N. Redmond, my predecessor, has recovered and returned to his practice, and to extend to him my thanks for the orderly manner of affairs in the Second District and his continued advice and assistance the past year.

Your trustee is grateful for the co-operation, help and advice of the officers, board, and personnel of the State Society office during the year 1967-68.

George E. Giffin, *Trustee*

THIRD DISTRICT

No report available.

FOURTH DISTRICT

The component societies of the Fourth District during the past year have been more or less active. Because of the variation in size, both urban and rural, it has been almost impossible to obtain speakers and create activities in these communities. Several of our smaller societies have one, two or three doctors and the cry is for more general practitioners to replenish the sagging number of doctors in these communities. As a result of this diminution, lists of local students attending Illinois medical schools are being collected and will be used in a recruitment program.

I wish to call your attention to the fine programs which were our good fortune to receive when in several counties we were visited by the president of the ISMS. I believe that the policy should be continued during the coming year. May I suggest that not only the president make up these tours, but also members of the staff which would have very good communication effect with the home office and the ISMS.

Of special mention was the project which concerned a physician who had been practicing in Galesburg, and at the present time is working in the Congo. The Knox County Medical Society endorsed a project to purchase a plane to be used by him in the Congo. The combined efforts were successful in raising the necessary funds.

In the Peoria district, a Diabetes Detection Program has been co-sponsored with the local Health Department and has proven very successful. Pilot council studies by both the Health Insurance and the Illinois Nursing Home Association have been helpful in establishing and improvement of insurance mediation and utilization review procedures at the county level.

In a number of the district counties, clinics for migrant workers during the summer months were held, staffed by volunteer physicians. Also public relations committees conducted education programs with reference to measles immunization during Community Health Week.

A bronze plaque was presented to the television station WQAD for producing the TV series, "Insight to Medicine."

Approved is the proposal of the University of Illinois Medical Center Extension Service to present a series of local programs on preventive medicine and public health.

During the year the district will participate with the ISMS as co-sponsors of regional public affairs meetings.

My gratitude to the officers and members of the county societies for the co-operation and courtesies extended to me. I wish to thank the headquarters staff for their help and co-operation given me.

P. P. Youngberg, *Trustee*

FIFTH DISTRICT

During this past year the eight component societies have continued to be active and co-operative in state society projects. The larger societies have regular scientific and business meetings. In an attempt to increase attendance, Sangamon County has a scientific and business meeting every other month during the fall, winter and spring seasons for a total of five meetings a year. To date this change from the monthly meeting has not produced the desired attendance result. However, it does ease the meeting burden required of us at hospital staff and committee meetings. The smaller county societies met only occasionally and then only as needed.

Sangamon County Medical Society has been very busy exploring and publicizing the assets of Springfield as a site for a future downstate medical school. Some of the same members are busy improving methods for "continuing medical education" for the members of the Springfield Hospital's medical and nursing staffs.

The Department of Mental Health opened The Andrew McFarland Zone Center to serve 18 counties in Zone V on Nov. 15. This center is located on a large tract of land immediately south of Springfield and, when completely opened, will have 180 beds for children, adolescents, adults and the mentally retarded. Dr. Charles E. Beck is the Zone Director.

A District Conference for all the members of the district and neighboring counties will be held at the McFarland Zone Center, with Sangamon County Medical Society as host, March 21. The conference will deal with The Retirement-Investment and Keogh programs and group insurance programs of the ISMS, trends in malpractice litigation and a professional liability program, and a tour of the Zone Center and an explanation of the community approach to mental health treatment. We hope this meeting will be well attended and helpful to the doctor economi-

cally. Likewise to assist mental health with their community programs.

To date there is only one known 50-Year Club recipient in the Fifth District. Dr. Ralph Loar of Bloomington will be honored at a dinner meeting of the members and their wives of the McLean County Medical Society in April.

At this moment the District constitutional committees have not had occasion to meet. All problems that have arisen have been handled at the local level, which speaks well for our local societies.

A meeting with the delegates and alternate delegates is planned with the March 21 District meeting and also just before the opening meeting of the House of Delegates in May.

It was my misfortune to be disabled by surgical complications last fall and as a result missed the October Board of Trustees meeting. Otherwise, I have attended all meetings, including the special December meeting of the Board of Trustees, the Journal Committee, and the Committee to Study Committees.

May I express my appreciation for the support and co-operation of the constituent medical societies and Dr. George F. Lull and his staff in Chicago and Springfield. I am very grateful to the officers and fellow trustees for their kindnesses and consideration this past year.

Darrell H. Trumpe, *Trustee*

SIXTH DISTRICT

No report available.

SEVENTH DISTRICT

The membership for 1967 in the Seventh District has shown practically no change in the past year. As stated a year ago, there is a great need for more general practitioners. This is being emphasized in numerous speeches by our President and President-Elect throughout the state.

The three district committees have had no calls for action during the past year from the 11 county societies.

Your trustee will offer the same excuse as of a year ago for this short report, much of which will be in the report of the Chairman of the Board of Trustees to the House of Delegates in May of 1968. Information and communications of the material posted has been well documented in the Journal of the Illinois State Medical Society.

Seventh District had no new Fifty Year Club members to honor.

The 11 constituent medical societies and auxiliaries have functioned smoothly throughout the year. Many problems do exist in the future outlook due to pressures of HEW and Medicare.

Arthur F. Goodyear, *Trustee*

EIGHTH DISTRICT

The past year has been a time of tension and considerable activity regarding Medicare and Public Aid. There have been unnecessary questions asked by the carriers of Medicare and by the administrators of Public Aid. There has also been marked delay in payment of fees.

There has been concern as to the necessity of requiring draft eligible physicians to submit to a physical examination by Selective Service regardless

of their status. This results in a waste of time and money.

Political activity of physicians has increased rapidly and markedly. A postgraduate conference in Champaign in October was well attended. On Jan. 15, a most interesting legislative conference was held in Danville with Mr. Robert Novak as the principal speaker.

No problems have arisen in the Eighth District which go unresolved. The trustee has been able to handle these with direct communication with the individuals concerned.

My compliments go to the delegates of the Eighth District for their participation in the activities of the House of Delegates. They have been articulate in presentation of their opinions and in the discussion and making of motions before the House of Delegates.

I would also like to thank the physicians from this district who have given so freely of their time and effort in attendance at committee meetings at the state level.

William H. Schowengerdt, *Trustee*

NINTH DISTRICT

The Trustee of the Ninth District attended most of the larger medical society meetings in his district during the past year. There appear to be no acute problems with the societies other than a shortage of physicians and generalized apathy toward the State Society. The doctors seem to be grateful for the new agreement between the Illinois State Medical Society and the Department of Public Aid, in spite of some delay in payments to some physicians.

There have been no problems brought before the District's Ethical Relations, Grievance or Prepayment Plans and Organizations Committees during the year.

The combined district meeting of the Ninth and Tenth Districts was held in conjunction with the Southern Illinois Medical Association meeting Nov. 9, 1967, in Belleville and was well attended. Dr. Henry Holle of the Department of Public Aid was present to answer questions.

I wish to thank the staff of the Illinois State Medical Society for their help during the past year.

Charles K. Wells, *Trustee*

TENTH DISTRICT

June 4, 1967—Speaker at the Junior College School of Nursing annual tea on the subject of "Horizons of Tomorrow and Self-Responsibility."

June 7, 1967—Speaker at Exchange Club, East St. Louis. Subject of Nurse Scholarship Association of St. Clair County—Its Aims and Functions. Exchange Club has singularly given a \$500 scholarship in memoriam. This year their scholarship was established in the name of Mr. Wm. Dunham, deceased, representative on the Nurse Scholarship Committee, in recognition of his many years of devoted service to the project. Miss Laws recipient of this year's scholarship.

June 18-21, 1967—AMA Convention, Atlantic City.

June 27, 1967—Installed as president American Association Maternal and Child Health.

July 12, 1967—St. Mary Hospital, East St. Louis, groundbreaking ceremony for first phase of expansion program. Total construction cost—\$4,119,510.

July 18, 1967—Passing of Dr. Peter Fajans, Okawville.

Aug. 24, 1967—Nurse Scholarship Tea. Awarding of 23 scholarships; 175 people in attendance. Tenth

anniversary of association's existence.

Sept. 20, 1967—Perry County Medical Society. All active members present. General discussion on events during past year in ISMS and AMA germane to their society. Concerned over extent of podiatrists professional practices in their area. Some concern over practice of occasional specialists failing to give adequate recognition to the time involved, services, and compensation of a referring physician in instructing patients to merely have the latter complete history and physical in order to facilitate the special services to the referred patient in the hospital.

Sept. 21, 1967—Regional Medical Program meeting, St. Louis (Bi-State Division). Dr. Joseph Ross, UCLA.

Sept. 28, 1967—Monroe County Medical Society. General discussion about pertinent and current matters involving school examination, failure of public aid to pay properly filled and coded bills to some of the physicians for as long as eight months. Combined expression of hope and desire that the AMA would adopt and promote a firmer support of the physicians' privileges and recognition in relation to government at all levels.

Oct. 17, 1967—Represented ISMS at direction of Dr. DuPuy, president, at Regional Foreign Policy meeting. Subject of conference—"America and the Troubled World." Explanation of United States foreign policy—past, present, and projected. Approximately 800 people in attendance.

Nov. 9, 1967—Combined 9th and 10th districts meeting, Belleville, in conjunction with Southern Illinois Medical Association 93rd annual convention. Interesting program highlighted by afternoon panel discussion on Medicare—Questions and Answers. Participants—Dr. Holle, Dr. Montgomery, Dr. Lehr, Dr. Wells (9th district councilor, Dr. Scrivner moderator. Exhibits—63. Physicians in attendance—125.

Nov. 16, 1967—Attended meeting Springfield, Dr. Yoder's office for comprehensive care—area program. Considered presentation by Missouri bi-state area program, Mr. Frank McDonald. Concluded one informal meeting, joint effort Missouri and Illinois Departments of Health with Monroe, St. Clair, and Madison counties—stipulating that any area plan be subordinated to the Commonwealth of Illinois as will be developed with provision of appeal from any area decision.

Nov. 25-28, 1967—Attended clinical session AMA, Houston, Texas.

Dec. 7, 1967—St. Clair County Medical Society dinner at Christian Welfare Hospital, East St. Louis. Dr. Philip G. Thomsen and Mr. Walter R. Livingston, assistant vice president Medical Surgical Plan of Illinois Medical Service spoke on "Usual and Customary Fees" and Blue Shield.

Dec. 13, 1967—Representatives of Bi-State Missouri side of comprehensive health planning meeting with Illinois representatives including Dr. Reeder and Dr. Sondag for explorative reasons. In summary the east-side representatives expressed interest in co-operation on a broad base and all agreed on the advisability of having any appeal body either consist of physicians or that the appeal body would act on medical service implementation only with the approval of a sub-committee of medical men.

Dec. 15, 1967—Report from Ethical Relations District Committee chairman on exoneration of a member of Washington County defendant; charge placed by Marion County Medical Society.

Jan. 18, 1968—Initial meeting of steering committee for medical advice on ghetto health, survey, and service at St. Mary Hospital, East St. Louis.

Jan. 23, 1968—Regular meeting Jackson County Medical Society. First meeting for president, Dr. Ballesteros. Good attendance; lively discussion on third party problems, comprehensive health planning and medical education.

Jan. 27, 1968—Impartial testimonial dinner for Congressman Mel Price, 24th District, at Belleville. Many physicians in attendance.

Feb. 7, 1968—Attended regular meeting of Washington County Medical Society, Okawville Hotel, Okawville. Three physicians and wives in attendance. Subject matter: some concern on part of members about professional ethics, scarcity of physicians. Report on current status of state society to members.

Feb. 15, 1968—Workshop on government health programs. Attended by approximately 150 medical assistants. Sponsored by ISMS.

Feb. 15, 1968—7th annual student nurses banquet sponsored by Nurse Scholarship Association of St. Clair County, St. Clair County Medical Society, East St. Louis Chamber of Commerce, Belleville Chamber of Commerce. 250 in attendance. Approximately 75 student nurses recognized and awarded gifts. Entertainment program.

Feb. 20, 1968—Second meeting Ad Hoc Steering Committee on ghetto health at St. Mary's Hospital, East St. Louis. OEO director, physicians, SIU Dr. Reeder, and Mr. Chaplin, Department of Health. Immediate project: to develop referral system for people involved, and program of health team assistants (nonprofessional) from people to be served.

Feb. 21, 1968—Lincoln Day Dinner, Belleville. MC—Dr. Wilson West, St. Clair County Medical Society. Honorable Tom McCall, Governor of Oregon, guest speaker. Many physicians and wives present.

Feb. 23, 1968—Address on medical ethics to St. Clair County unit medical assistants of Illinois.

Feb. 24, 1968—Meeting of Randolph County Medical Society. Resume of ISMS activities, Public Affairs Conference in Washington, D.C.; alert for possibilities and effects of Law 749. Election of society's officers.

REMARKS

Physicians and wives manifest sustained interest in health careers, legislation, and community programs. In some areas civil commotion, lawlessness, and fear for personal safety have had an effect on pattern of delivery of medical services.

W. C. Scrivner, *Trustee*

ELEVENTH DISTRICT

During the past year, your trustee attended all the scheduled meetings of the Board of Trustees. I am always impressed at the volume and importance of the decisions that emanate from the board. At times, several issues arose which were of such major importance that it was deemed necessary that the matter be referred to the House of Delegates at this May meeting for its decisions.

It is my earnest concern that all county medical society officers in the Eleventh District, avail themselves of the opportunity to have mailed to them the full minutes of the quarterly meetings of the board.

These may be received by sending a written request to the executive administrator at the headquarters office. I would suggest that all physicians read the summary of the actions of the board which are published in the Illinois Medical Journal. After each board meeting, I have communicated by mail with the officers of the county medical societies to give them what I considered pertinent information and comments.

Your trustee has served on several "ad hoc" committees of the board, and has recently been appointed chairman of a Task Force on Medical Education. This will require extensive study and comments which will be ready for presentation at the May meeting.

The Committee on Committees has again been active in streamlining the structure of the ISMS.

I would recommend your close attention to the report of the Committee on Usual and Customary Fees.

The Regional Health Planning Council and the Regional Medical Programs are at present our most important subjects of debate.

Will-Grundy County has been actively promoting the problem of communications within our society. The concept of a lay medical administrator, paid for by the local medical societies involved, who can coordinate the ever-expanding demands made upon the local societies is excellent. I recommend that the Committee to Study District Administrative Offices and the feasibility of such a program be reinstituted.

DuPage County has had an active year in its pilot preceptorship program which is being held in conjunction with the Chicago Medical School. The response of the students as well as the participating physicians has been gratifying. I would recommend that the Committee on Medical Education consider expanding this program to other areas of the state.

The work of the Board of Trustees is challenging and directly related to the practicing physician. It can best be of value to the county medical society if the local society itself will pick up the reports of the meetings, take an active role in informing your trustees of your needs and wishes, and to by all means take an active part in sitting on the State committees to which you are assigned.

Joseph R. O'Donnell, *Trustee*

TRUSTEE AT LARGE

As Trustee-at-Large of the Illinois State Medical Society, the responsibilities are much less and the duties fewer than President-Elect or President of the Society.

Nevertheless, the work continued and certain assignments had to be carried out. I have represented the Illinois State Medical Society on many occasions on radio, television, etc. I spoke to many groups on various subjects pertaining to the practice of medicine and the functions of organized medicine. I had to travel in a much lesser degree than previously and enjoyed very much meeting with the different members, discussing their problems and the problems of medicine in general.

Finally, I want to thank my colleagues for the honor that they have bestowed upon me the past three years. I hope that I have represented them well and have served the Society efficiently.

Caesar Portes

CHAIRMAN OF THE BOARD

The selection of a successor to Dr. Lull has been the most important single item on the agenda for the Chairman of the Board to consider. The board went on record officially endorsing a physician for this position. The recommendation of the "Committee to Study Headquarters Office" was to this effect, and the board concurred.

At the time this report is being prepared, some 14 physicians have indicated their interest in this position, as well as additional laymen, most of whom are well qualified. The list of physicians includes former medical officers of the Armed Services and the Public Health Service. Many of the men have excellent administrative experience and undoubtedly by the time this report comes before the House, a physician will have been selected to serve at headquarters.

The report of the Committee to Study Headquarters Office contained the following recommendations which were approved by the Board:

That a physician be employed to act as administrator

That assistant division directors be established to guarantee the orderly transference of responsibility if a director leaves ISMS

That better communications between divisions within headquarters be established

That a committee from the board meet at least twice a year with division heads, to discuss internal problems and to effect "long range planning"

That all grants for continuing education of employees be reviewed by this committee (composed of members of the board) and that grants be made on an individual basis by formal request

That a centralization of purchases with bidding on supplies be established

That all contracts of \$500 or more, be reviewed by the committee

That a local treasurer from the present board be appointed, with a term of no longer than three years (and not able to succeed himself). This will insure the actual double signaturing and review of checks, and will eliminate the use of any stamped signature

That uniform starting salaries and job descriptions be established

The work of this committee, with Dr. Frank J. Jirka as chairman, was considered thorough and outstanding. The establishment of board responsibility was long overdue and the importance of all trustees becoming more familiar with the employees, their procedures and their activities, must be considered most important. This information and knowledge should be part of the responsibility of trusteeship

The committee (Drs. Jirka, Giffin, Lees, O'Donnell and Warren Young) all signed the report, and all contributed to the decisions arrived at by the group.

Many of the items coming before the board find no assignment to our committee structure, or to the existing staff assignment. Therefore, they are included in my report as chairman.

An ad hoc committee was appointed at the request of Dr. Yoder for the purpose of developing a plan of co-operation with the Department of Registration and Education to work at the county medical society level to report unethical and illegal conduct of a physician and any case of a physician needing or receiving mental care. These are "touchy" problems, and ones which must be handled with tact and acumen.

The executive administrator was authorized to abstract the minutes of the board prior to mailing to members of the House of Delegates and officers of county medical societies. The complete minutes (sent to board members only under the new ruling) will be mailed to anyone who desires them and sends in a specific written request. However, when the minutes are mailed, a note must be attached to them stating that they are unofficial until action approving them has been taken by the Board of Trustees.

Resource Committee

A "Resource Committee" composed of past presidents was suggested and approved. This action makes available for the president and the president-elect (and other members of the board) the information gained by these past presidents through experience and service.

Changes in Executive & Finance Committee Meetings

Since the function of an executive committee is to act between meetings of the board (held every three months) the meeting of this group should be called at a time other than that of the board meeting itself. In this manner, the interim between meetings of the board is better covered and the problems of the society considered more in detail and at a better interval. By holding the meeting of the Finance Committee in a similar manner, more time and consideration can be given to society affairs.

Committee to Study District Administrative Offices

At the July meeting of the board the work of this important committee was discussed. The need for lay executive assistance at the local level throughout the state is obvious; however, the matter of financing such activity is the most serious obstacle at the present time. The state society, without additional dues structure, would not be able to assist except to provide field services from staff on a limited basis and in a limited area, confined to the various divisional breakdown existing in headquarters office. The committee was to be dissolved and the personnel thanked for its work.

Dr. O'Donnell reported at the October meeting that Dr. Becker, who was chairman of the Committee to Study Area Offices, expressed his opinion that the downstate counties should be encouraged to band together and secure clerical or secretarial help. Then perhaps the field service from headquarters office would be of more assistance, and would be useful on a more sustaining basis. Dr. Becker felt that this committee should be reactivated and its work continued.

Research Survey Information

The importance of the survey is particularly clear when the summary of recommendations is studied. The Chairman of the Board appointed Dr. Sunderland, Dr. Portes and Dr. O'Donnell to check on the work progress at headquarters for the purpose of implementing such programs as possible under the present dues structure, and in order to develop some type of priority listing to make the best use of existing funds.

The Regional Medical Program for Heart, Cancer and Stroke was submitted to the headquarters office

by Dr. Wright Adams, as project director for implementation of the planning grant. Dr. Leon O. Jacobson is project co-ordinator and chairman of the Coordinating Committee of Medical Schools and Teaching Hospitals in Illinois. Dr. Oglesby Paul is chairman of the Governor's Advisory Committee, and Dr. Roger F. Sondag serves as technical secretary of the committee.

Dr. Adams asked that the complete report of the regional planning program be sent out to all county medical societies, but the executive administrator requested that the material be condensed so that the county society secretaries would have a better opportunity to read the file. The complete record was sent to all trustees. However to date, (March, 1968) this condensation has not been prepared for mailing and no further action has been taken.

Concept of Voluntary Participation In the Evaluation of the Fitness to Practice Medicine

Request for House Action

The board was asked to consider approving the concept of voluntary participation by the physician in self-examination to determine fitness to practice medicine. Detailed discussion followed this request, and by official action, the board referred this request to the House of Delegates for consideration and action.

The national concern with the ability of individual physicians is apparent. The possibility that HEW will rule that a physician must show qualifications to care for welfare patients and the possibility that reexamination as well as license renewal would become a state and/or federal law, were discussed. Various opinions were expressed, including the suggestion that this entire problem be left for the discussion of the House. The motion to refer was adopted.

Also, if this program of self-examination meets with the approval of the House, then the AMA delegation should be instructed to develop a resolution for presentation at the San Francisco meeting of the House of Delegates, incorporating the concept of voluntary participation in the evaluation of the fitness of a physician to practice medicine; that the inauguration, the methodology, implementation and manner of disposal of the data accumulated under such a program, be a matter over which the several states have complete autonomy.

Special Committees, Ad Hoc Committees & Representatives To Other Groups

During the past year, it has been necessary for the chairman of the board to name special committees, ad hoc committees and representatives from the ISMS to other groups.

Perhaps all are not listed here, but the following represent a sampling of the diversified areas in which your society is active.

In October, 1967 the Department of Public Health submitted a list of names to act as the Department Advisory Committee on Renal Disease. The list included Drs. David P. Earle, Alan J. Kantor, Antonio A. Versaci, Robert M. Kark of the Chicago area, H. B. Henkel, Jr. of Springfield and James Meyer of Peoria.

Dr. Yoder also asked that a group of our physicians serve as the Immunization Advisory Committee to develop rules and regulations for "An Act in

Relation to the Prevention of Certain Communicable Diseases". (H.B. #1411). The group was headed by Dr. Ralph H. Kunstadter as chairman. The committee worked with Dr. Henry A. Holle, Medical Director of the Department of Public Aid.

Dr. Paul Van Pernis of Rockford was recommended for reappointment as a member of the Clinical Laboratory and Blood Bank Advisory Board to the Illinois Department of Public Health.

The names of the following physicians were submitted to Dr. Yoder to be used in connection with the educational program for work in the field of water and air pollution: Drs. Newton DuPuy, Philip G. Thomsen, Arthur F. Goodyear, Frank J. Jirka, Edward A. Piszczek, William E. Adams, William M. Lees, Thomas P. deGraffenried, George E. Giffin, Darrell Trumpe, Charles Asbury (Caterpillar Tractor Co.) and Frank Bihss.

The Ad Hoc Ambulance Study Commission to work with representatives of the Illinois Funeral Directors Association was appointed: Drs. Max Klinghoffer, Harold C. Lueth, Colman O'Neill, James Kurtz and William Hark.

Dr. John J. Ring, (who has served as alternate) was asked to replace Dr. Samuel Weingarten on the Council of Professional Societies of the Mental Health Planning Board.

The following names were submitted to Dr. Yoder as suggested members of the Statewide Planning Committee: Drs. Walter C. Bornemeier, Philip G. Thomsen, Willard C. Scrivner and William H. Schowengerdt.

Dr. Henrietta Herbolzheimer and Dr. Harold A. Sofield were recommended to Dr. Yoder for reappointment on the Commission of the Illinois Public Health Study Survey.

Dr. Caesar Portes was asked to serve on the Advisory Committee to the Regional Medical Program for Heart, Cancer and Stroke (recommended for the appointment by ISMS).

An ad hoc committee from the ISMS was appointed to meet with a similar group from the Illinois Hospital Association for the purpose of discussion of the "Corporate Practice of Medicine". Representing the state society are Drs. Newton DuPuy (chairman), Philip G. Thomsen, Harold A. Sofield, H. Close Hesseltine and V. P. Siegel.

Dr. George Lull replaced Mr. Richards as the society representative on the Interagency Commission on Smoking and Health.

Dr. Edward A. Piszczek attended the 11th National Conference on Physicians and Schools (AMA sponsored) as the official representative of the Society. It was his 11th meeting, and he was so honored.

Dr. William E. Adams is a member of the Regional Library Council, and reports regularly to the Board.

Dr. Arkell M. Vaughn was reappointed a member of the Board of Trustees of the Swanberg Foundation.

Within the board itself, two ad hoc committees have been appointed, and have served with distinction (1) the Ad Hoc Committee to Study Headquarters, with Dr. Jirka as chairman, and (2) the Ad Hoc Committee to Study Data Processing with Dr. Carl E. Clark in charge.

Two Task Forces Requested

At the last meeting of the Board of Trustees, the request for the establishment of a "Task Force on

Education" and a "Task Force on Health Planning" were requested. The board approved the establishment of the two groups, but no budgetary provisions were made for either, nor were any suggestions relative to financing offered.

Therefore, in the case of the Task Force on Education, the following action has been taken by the Chairman of the Board:

Dr. Joseph R. O'Donnell has been named chairman, with Drs. Philip C. Lynch, Jack Gibbs and V. P. Siegel as members. This group is to meet with Dr. Carl E. Clark as chairman of the Finance Committee to work out financial programming of the Task Force before any action is taken.

The Task Force on Health Planning should have very little expense during the 1968-1969 year (according to Dr. V. P. Siegel), and he suggested that certain portions of the committee budgets already established, be allocated to this task force and to the coordination of the Health Planning Program to keep it within the present committee budget framework. Dr. Siegel was named chairman of the Task Force with Dr. Philip C. Lynch as a member. These two men are to meet and suggest the names of three others for appointment.

Arthur F. Goodyear

EXECUTIVE ADMINISTRATOR

All resolutions passed by the House of Delegates in May, 1967, calling for reference to various councils and committees have been so referred. The following were considered by the Board of Trustees of ISMS and action taken as follows:

Resolution 67M-3: Introduced by Lake County was a protest of AMA's action in recommending that the medical portion of Title XIX Public Law 89-97 be administered by Public Health Departments. It was found that the action of the AMA pertained only on a national level. Individual states would have to make their own determinations.

Resolution 67M-6: Introduced by Clark County was referred to the Advisory Committee to the Illinois Department of Public Aid for a recommendation prior to bringing it before the ISMS Board of Trustees.

The Committee reviewed the resolution which originated in Clark County and dealt with the right of a physician to bill the department direct for services. The committee chairman stated that it enthusiastically encourages the implementation of the resolution, as it was approved by the House at the May, 1967 annual meeting. The ISMS Board concurred.

The matter was then referred to Mr. Harold O. Swank, Illinois Department of Public Aid, who replied explaining why the department could not do this at the present time. Primarily it would mean obligating a large amount of state funds prior to obtaining matching funds. It was conceivable that such state funds might not be available.

Resolution 67M-18: Authorized an appropriation of \$2,500 to the Archives Committee for the "150 Sesquicentennial Committee" which was made available upon the presentation of a budget.

Resolution 67M-21: Authorized the payment of \$2 for each dues paying member to the Health Careers Council. This was to be deducted from the \$20 each member pays to the AMA-ERF fund. The money has been paid.

Resolution 67M-29: This resolution, relative to a proposed action by the Joint Commission on Accreditation of Hospitals prohibiting the use of medical students as externs in any hospital but those hospitals connected with medical schools.

The Chairman of the Board of Trustees appointed Drs. Philip Thomsen, William Lees and Caesar Portes as a committee to request a conference with the JCAH. These physicians appeared before a committee of the JCAH and stated the views of the society to be presented to the commission.

Resolution 67M-33: Introduced by the Peoria Medical Society, concerned physical therapists and their activities. Some of these individuals have set up groups, are advertising and are being referred to by nursing home proprietors as "consultants."

The Illinois chapter of the American Physical Therapy Association deplores these activities, most of which are contrary to their established code of ethics. These individuals were allowed to register under the "grandfather" clause in the law passed in 1965 making mandatory registration effective Jan. 1, 1967.

This matter was referred to our legal counsel for an opinion as to whether there is any way to have the Department of Registration and Education set up some method of reviewing complaints and taking action against violators of the act.

Our legal counsel has advised us of the limitations imposed on physical therapists under the law and requested that documented violations be furnished him so that he could take the matter up with the proper authorities.

Resolution 67M-37: Introduced by Frederick Weiss, M.D., concerned the supply and distribution of physicians. The Board of Trustees referred this resolution to the Council on Medical Education.

The following resolution on chiropractic was passed unanimously by the Board of Trustees and distributed as shown in the last "resolved":

"WHEREAS, An attempt is being made to certify chiropractors under Title XIX of the Medical Assistance Program, and

WHEREAS, Chiropractic is a cult without any scientific foundation, and

WHEREAS, Chiropractic "treatment" may do serious harm to the patient, therefore be it

RESOLVED, That the Executive Committee of the Illinois State Medical Society representing ten thousand physicians in Illinois urges that no funds be authorized for payment of chiropractors, and be it further

RESOLVED, That a copy of this resolution be sent to the Secretary of Health, Education and Welfare and to each member of the Committee on Finance of the Senate.

In the fall of 1967, Dr. Franklin Yoder, Director, Public Health for Illinois, called a conference of interested people in the Health Care of the Poor, especially in slum areas. Representing ISMS were Drs. Goodyear, Thomsen and Lull. Chicago Medical Society also had representation.

On Dec. 15-16, the AMA scheduled a national planning Conference on Health Care for the Poor held at the Palmer House, Chicago. The conference (sponsored by the AMA Board of Trustees and the Council on Medical Service) was to profile social, cultural, health characteristics of the poor, etc. Attendance was by invitation and was composed of two representatives from each state medical association,

two from the larger metropolitan area county societies and officers of certain national voluntary organizations, selected governmental officials and physicians involved in specific programs to provide health care for the poor.

Representatives of the University of Illinois School of Medicine discussed with the Board of Trustees methods of handling fees for professional service at the University of Illinois hospital. Physicians were not allowed to charge patients in these hospitals until the recent session of the legislature when H.B. #31 was passed authorizing direct billing to patients or third party carriers.

The Board of the Illinois State Medical Society understood that physicians would submit bills for their services under their own names and then, upon receipt of the fees, might dispose of them as they saw fit (including turning them into a fund to be used as directed by the staff).

The plan adopted followed this procedure but stipulated that the dean could veto any staff action. The Board of Trustees does not concur in this as it is thought to be contrary to the agreement reached prior to the passage of the bill.

The Chairman of the Board of Trustees has called meetings of the Executive Committee two weeks prior to each of the ISMS Board meetings and the Chairman of the Finance Committee has called meetings in similar manner. This has been of advantage in allowing more time for deliberation and the preparation of an informative report.

Opinion Research Survey

The report submitted by the Special Committee to Study the Opinion Research Survey, as adopted by the House of Delegates in May, 1967, has been referred to the various divisions of the headquarters office for implementation. In certain areas lack of funds has presented difficulty in complete compliance with the recommendations. In so far as possible the recommended actions have been put into effect. A report of these actions is as follows:

Modern data processing has been adopted for membership, mailing and billing. Expansion of this program is visualized but it will require an expenditure beyond this year's budget.

Resolution #11, requiring the Ad Hoc Committee on the Special Problems of Medical Education to make quarterly reports to the board is not applicable as the committee has been discharged. Under the new council system, the Chairman of the Council on Medical Education reports to the board at each of its regular meetings. The Committee on Medical Education, under its new chairman, Dr. Morgan M. Meyer of DuPage County, has been quite active this year, holding well attended meetings. Representatives of medical schools and clinician members of the committee have, we believe, established a good working relationship under Dr. Meyer's chairmanship.

The recommendation regarding integrating post-graduate education programs with the five medical schools should probably now fall within the province of the Council on Medical Education, which has already expressed concern over the state of post-graduate education in Illinois. The Committee on Continuing Education expects to explore in depth the role of the state medical society in this area when it meets March 6, 1968. (This report is of March 1 in order to have it in the handbook.)

The JOURNAL instituted color on its cover,

rather than black and white, immediately following the Task Force recommendation. The Editorial Board has discussed the use of colors to designate the various parts of the JOURNAL, such as yellow for socio-economic and legislative, blue for office management, etc., and took the position that this format would not be too practicable, but that it was a decision to be made by the Journal Committee rather than the Editorial Board.

The Editorial Board welcomes good papers presented at symposia such as that conducted on narcotics. The Editor asks, however, that organizations or divisions of the Illinois State Medical Society arranging such symposia notify him well in advance of their plans; and that speakers be told their papers will be considered for publication. In other words, the contents of the JOURNAL must remain under the jurisdiction of the Editor, and sponsors of symposia and speakers at same should not assume that papers from these meetings will be published as a matter of course, without consideration of other factors that may be involved.

Thus far the Editorial Board, Editor, and staff have been unable to find anyone to assemble material for a regular feature on office administration and business practice as recommended by the Task Force. The Editorial Board discussed this subject at its most recent meeting and supports the Editor in his request that at least four samples or installments of any regular feature be submitted for approval before the JOURNAL begins to publish anything of this nature.

Original manuscripts are always welcome from any member of the society, and the Editor calls particular attention to the need for editorials or short opinion articles or essays.

The Editorial Board considers impracticable the recommended page for interns and residents. In the judgment of the board, a listing of hospitals seeking house staff members would not only be a list of almost all hospitals approved for interns and residents, but might lead to some form of hospital raiding. It was the opinion of the board that there are in existence suitable channels for interns and residents to make connections with hospitals.

Most, if not all, hospitals are now receiving a free copy of the JOURNAL. It may be that these are addressed to the administrator and it would be up to the Journal Committee to decide if multiple copies could be sent to hospital librarians without undue expense.

Negotiations to combine the annual meeting of the Illinois State Medical Society with the Clinical Conference of the Chicago Medical Society have been discontinued in accordance with the wishes of CMS. The following organizations do participate in the ISMS annual meeting: Illinois Surgical Society, Illinois Obstetrical and Gynecological Society, Physicians Association of Illinois Mental Health Department, Illinois Academy of General Practice, Illinois Chapter, American Academy of Pediatrics, and Illinois Chapter, American College of Radiology.

Some time ago the staff explored the possibility of including physician art in its annual meeting exhibits and found that much more is involved in such an exhibit than one might think. Professional assistance is required not only for judging but also for displaying, lighting, etc. No recent headway has been made, but if we begin planning immediately, it should be possible to stage such an exhibit during the 1969 annual meeting.

The central clearing house for material concerning possible and probable legislation at all levels of government is being done informally. This is on a small scale through our various publications but is not near the size or scope envisioned as few members have sent in anything.

No action has been taken on the recommendation that we should furnish legislative information and methods to all medical students at schools within the state whose homes are in the state as well as all society members, in an effort to educate them to their rights, privileges and duties as citizen physicians. Both manpower and budget are lacking.

With reference to supplying information to designated "key men," the current emphasis is on Public Affairs rather than Legislation per se because 1968 is an election year. The "key men" in county societies are being regularly alerted and informed through a special Public Affairs Chairman's Bulletin which goes along with the monthly "On the Political Scene." Contacts are also being made with the county societies through field work.

Relative to the Public Relations area, the Reference Committee suggested a re-evaluation of our public relations program, including our health education projects. This was done with the result that—while continuing all Dr. SIMS programs—we shifted the emphasis of our PR programming from health education to socio-economic subjects. An example of this is the "President's Tour," which took our president and president-elect on a tour of 10 cities where they addressed service organizations, county medical societies and held radio, TV and press interviews to inform the public of medicine's views. Another example is our Workshop on Government Health Programs held first in St. Clair County. The program, to acquaint physicians and their medical assistants with the complexities of government health programs, proved so popular that similar workshops are being planned for other areas of the state in 1968-1969.

To bring my report to a close I wish to add that the co-operation of the employees at the headquarters office has made this past year a pleasant one for the undersigned. The Illinois State Medical Society members are fortunate in having such experienced and devoted employees on its staff.

George F. Lull

SPEAKER OF THE HOUSE OF DELEGATES

Following the questionnaire prepared and mailed last year to each delegate asking for criticisms and suggestions for the operation of the House, the present speaker also will try to incorporate some of this material in the program schedule.

We will call to your attention the following suggestions made in 1967:

1. Finish all reference committee reports on Tuesday regardless of any evening program schedule.
2. Clear Wednesday for elections and early adjournment in order to allow for train connections and the close of the exhibits, etc.
3. Reduce all formalities and unproductive appearances before the House and limit the time involved.
4. Encourage members to confine detailed discussions to their appearances before reference committees rather than to continue them on

the floor of the House.

5. Limit debate and the number of times any one individual can speak on any one subject.
6. Try to limit acceptance of resolutions to "prior to meeting" unless accepted by unanimous consent of the House. (The definition of "prior to the meeting" should be at least 24 hours before the convening of the first session of the House).
7. Start all reference committees on time (7 p.m. on Sunday evening).
8. Have reference committee reports available for distribution as soon as possible. Prior to the Tuesday session is most important so that the recommendations of the committee can be discussed prior to floor action.

The Sunday session should recess by 5 p.m. in order that the reference committees can open by 7 p.m.

No recess hour is set for the Tuesday session since as many reference committee reports will be heard as possible prior to adjournment.

The pamphlet "Your Role as a Delegate" written and prepared by the former Speaker of the House, has been updated and the changes in the Bylaws incorporated. The new edition will be distributed to all delegates and members of the House.

For the first time the privilege of the floor (but not voting rights) are available for past presidents, AMA delegates, AMA officers, and past trustees. Special ribbon badges have been ordered for all VOTING members of the House, to afford instant recognition by the Sergeants at Arms and Tellers.

For the first time the reports are to be published for the House by "Councils" under the new Bylaws. This has presented some problems during the year, and some during the assignment of reports to the various committees. However, after another year's experience, perhaps more efficient and better organized reports can be submitted. The reports to the AMA House of Delegates made by the Councils on Medical Service and Medical Education are excellent examples of the manner in which we eventually hope to prepare material for the consideration of our House.

At the time this report was prepared, not one resolution had been received in the headquarters office. An emergency letter was mailed to all county society and lay secretaries by the Executive Administrator with a copy to all county society presidents. In order to assist the members of the House, resolutions received too late for publication will be mailed to delegates from time to time. However, this puts an added load on the personnel at headquarters and may not always be possible.

The general format to conduct the business of the House in 1968 remains the same:

SUNDAY, May 19

- | | |
|--------|--|
| 2 p.m. | Committee on Credentials |
| 3 p.m. | HOUSE OF DELEGATES—Opening Session |
| | Introduction of Resolutions, reports, etc., and referral to correct reference committee. |
| 7 p.m. | Reference committee meeting—Open hearings |

TUESDAY, May 21

- | | |
|-----------|-----------------------------------|
| 1:30 p.m. | Committee on Credentials |
| 2 p.m. | HOUSE OF DELEGATES—Second Session |

To hear reference committee reports
WEDNESDAY, May 22
 1:30 p.m. Committee on Credentials
 2 p.m. HOUSE OF DELEGATES—Closing session
 To hear remaining reference committee reports
 Election of 1969 officers, AMA delegates, etc.
 Induction of Philip G. Thomsen into office of President
 Any suggestions which might develop more efficiency in the conduct of the business of the House will be sincerely appreciated by the Speaker.
 Maurice M. Hoeltgen

VICE SPEAKER

I have followed in the footsteps of the Speaker, Dr. Hoeltgen, attended all Board of Trustee meetings, and tried to be of service to you members of ISMS.

The most interesting activity was that of joining with ISMS to enjoin the State Department of Revenue from charging sales tax on medicine dispensed by physicians.

Assisting in selecting reference committee members and chairmen and the order of business for the annual meeting was a challenging task. Here and now, I enter a plea to all component societies to elect their delegates and send their names to the ISMS office on or before Jan. 31 each year. This one assist from you will simplify and expedite the matter of selecting good committees to hear, act on, and report to you the affairs of our Society, which is YOU.

Paul W. Sunderland

AMA DELEGATION

The AMA delegation has closed another successful year, with Walter C. Bornemeier as speaker of the House of Delegates, and Burtis E. Montgomery elected as a member of the Board of Trustees and serving that body as a member of its executive committee, and members of our delegation active in many areas and Illinois physicians serving on AMA Councils and committees.

Atlantic City—June

At the June meeting in Atlantic City, the Illinois delegation introduced resolutions dealing with:

1. Agreement between UMW and the Social Security Administration
 House action: That the relationship between UMW and the SSA depends upon understanding and education. No action was taken by the House.
2. Care of the Patient under Title XIX
 The House did not adopt this resolution which dealt with the "AMA position that implementation and administration of federal health programs (other than those of the armed forces and the VA) should be under the Surgeon General of the USPHS." The resolution expressed concern over potential results of carrying this position to the state level in implementation of Title XIX.
3. National Legislation Regulating Use of Flammable Fabrics. This resolution was amended and adopted.

4. Personnel of Commission on Graduate Medical Education. This resolution was referred to the Council on Medical Education and the Council on Medical Service for consideration.
5. Certification and Recertification for the Hospitalization of Medicare Patients. The House amended the resolution and recommended the reiteration of the current AMA position; continuation of endeavors to delete from the law the stipulation requirements for certification and recertification and the establishment of measures to insure against arbitrary imposition by hospital authorities of procedures that are not required under the law.
6. Functions of Utilization Review Committees. The House amended the resolution and reaffirmed AMA policy as set forth in the report of the Board.
7. Joint Commission Rulings regarding Use of Externs. This resolution was amended and adopted.
8. AMA Disability Insurance. The House voted to authorize the Board to make every effort to continue the AMA Group Disability Insurance without change in the present eligibility provisions and premium/benefits structure.

Reference Committee H—

Leo P. A. Sweeney, *Chairman*

Reference Committee on Rules and

Order of Business—Frank H. Fowler, *Member*

The Illinois luncheon was held on Monday noon, and again proved to be one of the highlights of the meeting.

Houston, November 1967

At the Houston meeting, the House of Delegates paid tribute to Dr. Percy E. Hopkins, immediate past chairman of the AMA Board of Trustees. Rather than presenting a resolution, Dr. Hoeltgen joined the chairman of the AMA Board in signing and reading a statement honoring Dr. Hopkins for his many contributions to medicine through the years. The AMA-ERF check from the Illinois State Medical Society, presented by Dr. DuPuy as president, was made in Dr. Hopkins honor. It totaled over \$160,000.

Illinois Resolutions:

Resolution #24 was approved. It instructed the board to direct its AMA members of the Joint Commission on Accreditation of Hospitals to press for prompt revision of the Commission's ruling on the use of externs in non-university affiliated hospitals, with the incorporation of adequate safeguards to insure the quality of programs for extern education.

Resolution #25, approved by the House, requested the Food and Drug Administration to disseminate recall information to physicians and pharmacists prior to public release when a product is removed from the market.

Illinois physicians active in Houston:

H. Kenneth Scatliff—a member of the Committee on Credentials

Jacob E. Reisch—a member of Reference Committee H (Miscellaneous Business)

Maurice M. Hoeltgen—chairman of the Reference Committee on Amendments to the Constitution & Bylaws

Walter C. Bornemeier—Speaker of the House of Delegates

Paul Holinger—attended his last meeting as delegate from the Section on Otorhinolaryngology

Henry A. Holle—Delegate from the Section on Preventive Medicine

Maynard L. Shapiro—Alternate delegate from the Section on General Practice

Wright R. Adams—Alternate delegate from the Section on Internal Medicine

All members of the House are to receive copies of the report of the National Advisory Committee on Health Manpower. The importance of health planning and the material presented in this publication should assist Illinois in maintaining the lead in this important area.

The Illinois luncheon, scheduled for Monday, June 17, 1968, in San Francisco, will honor Dr. Walter C. Bornemeier, a candidate in San Francisco for Speaker, and in 1969 a candidate for President-Elect of the American Medical Association.

Maurice M. Hoeltgen, *Chairman*
William K. Ford, *Secretary*

PRESIDENT OF WOMAN'S AUXILIARY

To the Members of the House of Delegates:

The first published mention of a Woman's Auxiliary to the Illinois State Medical Society is found in the July, 1927, issue of the *Illinois Medical Journal*.

A meeting of the doctors' wives was held in Moline June 2, 1927. A temporary organization was formed, which became permanent in 1928. We are, therefore, celebrating our 40th birthday this year.

At the time of organization the slogan was: Our Husband; Our Homes; Our Community; Our County.

The officers for 1928-1929 were:

Founder Pres. Mrs. G. Henry Mundt of Chicago
1st V. Pres. Mrs. W. D. Chapman of Silvis
2nd V. Pres. Mrs. C. C. Ellis of Moline
3rd V. Pres. Dr. Edith Lowry of St. Charles
Record. Sec'y. Mrs. J. O. Kletcher of Tuscola
Corres. Sec'y. Mrs. James Hutton of Chicago

As your president traveled through this beautiful and fertile State of Illinois to district meetings, to county meetings and training courses, she listened with admiration to the accounts of early Auxiliary life in Illinois. There were also long stories of current events, which will be history for the future.

The following were duties executed during this president's term:

1. Served as Presidential Delegate to the Annual Convention in Atlantic City. Our full quota of delegates and alternates were present at all the business and voting sessions.
2. With the assistance of the ISMS and the Auxiliary Corresponding Secretary, the Auxiliary State Directory was assembled and distributed.
3. An article on the "Future of the Auxiliary" was submitted to the *Illinois Medical Journal*.
4. An article on Illinois Auxiliary was written for the September, 1967, publication of *Chicago Medicine*.
5. A monthly greeting was written for "PULSE."
6. Your president chaired the following meetings:
 - a. Post convention board meeting
 - b. The fall board meeting
 - c. The Leadership training course for Auxiliary members which was held in Springfield
 - d. Acted as moderator for the Leadership Panel at the WASAMA 10th Annual Convention

e. Addressed the WASAMA House of Delegates and brought greetings from the Woman's Auxiliary to the ISMS

f. Spoke at 9 District Meetings and 15 County Meetings.

7. Attended the following meetings:

- a. Woman's Auxiliary to the AMA Fall Conference for state presidents and presidents-elect in Chicago
- b. Convention planning meeting
- c. Budget planning
- d. Three legislative meetings of the ISMS
- e. Two Nursing Committee meetings of the ISMS representing the state Auxiliary
- f. An Executive Committee board meeting of the ISMS Auxiliary
- g. Advisory Committee meeting with the Executive Board of the Auxiliary
- h. Third District Community Service meeting
- i. Clinical Conference of Chicago Medical Society Auxiliary
- j. Meetings with chairman of standing committees pertaining to their projects.

A continuous correspondence was held with the officers, directors, chairmen of standing committees and councilors through the year. Where it was more expedient the business was carried on by telephone.

The progress which the Woman's Auxiliary to the ISMS had experienced this year was due to the dedicated work of each county president, her officers, directors and chairmen. The district councilors had excellent meetings which were open to the public because of the community health interests. One of the largest district meetings instructed community agencies on how to establish a program on Home Health Services. The state committee chairmen were instrumental in presenting plans for projects of which county auxiliaries availed themselves.

We were happy to invite to our convention meetings the presidents and presidents-elect of our neighboring states. Our guest of honor was the president-elect of the Woman's Auxiliary to the AMA, Mrs. C. C. Long of Arkansas.

Our 41 organized counties and 107 members-at-large are all working to extend the doctors' helping hand into the community.

The Priority Projects this year have been as follows:

1. Aging. Hundreds of senior citizens have been visited, registered to vote and entertained by Auxiliary members and their children.
2. Contributions to AMA-ERF have totaled about \$3,000. Final figures will be available in May.
3. Benevolence contributions are now well over \$3,100.
4. Legislation and Public Affairs have been stressing involvement, and how best to work effectively for the party of your choice. Stress was placed on information relative to medical legislation.
5. International Health activities have sent thousands of pounds of drugs and supplies to needy hospitals overseas. Foreign physicians and friends have been entertained by our doctors and their wives.
6. Allied Medical Careers. Concentrated on bringing informative material, monies and speakers to junior high schools and high school students. Many nursing scholarships have also been awarded.

7. In the mental health field, emphasis was placed upon distributing information regarding the new concepts of psychiatric treatment. What is available at the new mental health centers. Information regarding Suicide Prevention Centers.
 8. Safety emphasized primarily safety in the school, in the streets and in the home. Emergency first aid booklets have been distributed.
- A temporary committee for "Program Enrichment" was approved by the Medical Advisory Committee. The purposes and functions of this committee will be to:

1. Keep abreast of programs at the national level.
2. To be informed about program needs at county level.
3. To provide trained committee chairmen capable of bringing enriched programs to county, regional and state meetings.

The state and county auxiliaries invite the doctors' wives who have not yet become members, to join their county Auxiliary.

Anna Spellberg, *President*

Committees of the Board of Trustees

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Some of the Auxiliary members have asked the Advisory Committee why husband and wife billing for dues had not been developed in accordance with the directive of the House of Delegates.

The attention of the Auxiliary was invited to the fact that the House of Delegates' action had been to approve this method of billing; however, such billing was to be developed *only* in those counties where the local medical society so desired.

The difficulty in Illinois results primarily from the variance in the fiscal year between the Illinois State Medical Society and its Auxiliary. The Auxiliary year coincides with that of the American Medical Association (June 30-July 1). The suggestion made by the Advisory Committee was that the women consider changing their fiscal year to correspond to that of the Illinois State Medical Society, which is the calendar year.

Philip G. Thomsen, *Chairman*
Newton DuPuy Arthur F. Goodyear

COMMITTEE ON ARCHIVES

The Committee on Archives in keeping with its responsibility of commemorating special observances, and co-operating with other agencies in matters of historical interest has made a special effort in celebrating the Sesquicentennial of the State of Illinois.

On March 12, 1967, the Board of Trustees of the Illinois State Medical Society approved the creation of a "Medical Committee of 150" to act in liaison with the Illinois Sesquicentennial Commission for the sesquicentennial celebration in 1968.

Such a committee has been formed and is geographically representative of the entire state. The names of the members of this committee have been given to their respective county sesquicentennial chairmen with whom they will be co-operating on local sesquicentennial projects.

The Committee on Archives has also retained the use of an exhibit of "A Doctor's Office in Early Illinois." This exhibit will be placed at various strategic sites throughout the State. Arrangements have been made to place the exhibit at the 1968 ISMS Annual Meeting and Illinois State Fair.

The Committee on Archives has also sponsored a monthly series of articles on Medical History in Illinois in the Illinois Medical Journal. This series will continue throughout the sesquicentennial year. In the January issue of the Journal appeared an article

entitled "Medical Education in Early Illinois" which was written by your chairman. In the February issue there was published an article on "Early Obstetric Practice in Illinois" by Frederick Falls, M.D.

Over 20 medical writers have pledged articles for this series. Each of these articles will be colorfully illustrated. Plans have been made to compile them into a special sesquicentennial booklet on Illinois Medical History.

Your committee has also joined with the Public Relations Committee in sponsoring and promoting a Sesquicentennial Luncheon at the 128th Annual Meeting in honor of the members of the 50-Year Club. The Medical Committee of 150 is promoting the luncheon, and many of its members are planning to attend. The Archives Committee has arranged to have W. Dan Snively, M.D., Vice President of Medical Affairs for the Mead-Johnson Co. address the luncheon. Dr. Snively who is a prominent writer and lecturer on medical history will speak on "Doctor Anna and the Milk Sickness."

Although most of the energy of the Archives Committee has been directed toward the observance of the Sesquicentennial, it continues to be interested in the creation of a permanent historical exhibit in Springfield, and also the preparation of Volume 3 of the "History of Medicine in Illinois." It is the hope of the committee that when adequate financing is available these projects will be pursued.

Emmet F. Pearson, *Chairman*
Carl W. Hagler H. Kenneth Scatliff
Leo Zimmerman

COMMITTEE TO STUDY COMMITTEES

The Committee to Study Committees met and discussed in detail the composition of the councils and committees, their duties and responsibilities.

The opinion of the committee was that only after at least two years experience and a report from the chairmen of the committees and councils can any changes be made.

Some of the committees may be combined but an experience factor is also needed in this area. The committee felt that the council arrangement was beginning to function and that it will provide greater efficiency and less loss of time when it becomes better understood. This system should also provide a financial savings to the Society.

William H. Schowengerdt, *Chairman*
Joseph R. O'Donnell Charles K. Wells
Darrell H. Trumpe William W. Young

COMMITTEE ON CONSTITUTION & BYLAWS

The Committee on Constitution & Bylaws has received only one new item for its consideration this year. It has, however, received notice of three areas where the changes in committee structure adopted by the House of Delegates require clarification or modification.

The new item brought to the Board of Trustees' attention by legal counsel pertains to the Journal subscription rate for members of the Illinois State Medical Society, as published in the Bylaws. It is possible that the subscription fee income may be considered by the Department of Internal Revenue as Journal income and as such, taxable.

When the House of Delegates was asked to approve the changes in committee structure at the last annual meeting, it was given the option of creating the Ethical Relations Committee through two different mechanisms. It approved the appointment of the committee by the Board as detailed in CHAPTER XII, Discipline, Part 2, Illinois State Medical Society Procedures, Section 7, but was not asked to remove the committee from the Judicial Council.

The Board of Trustees has operated by honoring the method approved by the House while neglecting the other method obviously intended by the House to have been removed from the Bylaws.

With the approval of the changes in committee structure, the House of Delegates authorized the Board of Trustees to establish other councils from time to time. In locating the existing committees of the society into appropriate and related groups under the council structure, the board has found that two named councils could be abolished and two others established. It has therefore recommended that the Medical-Legal Council and the Council on Third Party Medicine be deleted from the list of standing committees (called Councils) and that a Council on Legislation and Public Affairs, and a Council on Scientific Service be substituted.

The board has also recommended that the duties of the Council on Medical Service be restated in the Bylaws.

There have been several requests from county societies for a prototype of a county society constitution and bylaws. The suggestion was referred to the committee by the Executive Administrator of the Society. The prototype will be developed and made available.

Andrew J. Brislen, *Chairman*
David S. Fox Wayne N. Leimbach
Carl Weissmann

THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The principal activity of the Educational and Scientific Foundation during 1967 was operation of the Scientific Speakers Bureau, which is underwritten by a \$5,000 grant from Merck Sharp & Dohme.

During the year, 12 county societies used the services of the Bureau to arrange scientific meetings, and postgraduate programs were conducted in Centralia, Marion County, and Champaign, 8th District.

Following is a list of county medical societies using the service, the number of meetings using bureau speakers and the number of physicians who spoke at these meetings.

Bureau County—7 meetings, 7 physicians
Coles-Cumberland County—4 meetings, 4 physicians
Jo Davies County—1 meeting, 1 physician
De Kalb County—1 meeting, 1 physician
Kane County—7 meetings, 7 physicians
Knox County—5 meetings, 5 physicians
La Salle County—9 meetings, 9 physicians
Livingston County—7 meetings, 7 physicians
Macoupin-Montgomery County—3 meetings, 3 physicians
Rock Island County—2 meetings, 2 physicians
Southern Cook County Branch—CMS—3 meetings, 3 physicians
Vermilion County—1 meeting, 1 physician
Whiteside County—8 meetings, 8 physicians

During 1967, the following became Fellows of the Foundation: Charles Downey, M.D.; G. E. Giffin, M.D.; James B. Hartney, M.D.; Mather Pfeifferberger, M.D.; and Harold A. Sofield, M.D. The directors also gratefully acknowledge a contribution of \$195 from Paul W. Sunderland, M.D.

The film "Modern Management of Multiple Births" which was produced several years ago under the foundation's auspices continues to be shown throughout the county with no appreciable decrease in the number of requests.

No new sources of income were uncovered during the year, which is unfortunate as there are several projects in which the foundation could be interested if funds were available.

Caesar Portes, *Chairman*
Newton Du Puy Arthur F. Goodyear
Jacob E. Reisch

JOURNAL COMMITTEE

The year 1967 was an eventful one for the *Illinois Medical Journal* with positive and negative developments during the year continuing on into 1968.

On the sunny side of the ledger, it was a banner year for *Journal* advertising income. Gross income rose to \$149,389 from \$101,000 in 1966. In the memory of this committee, 1967 was the best year financially for the *Journal* in the history of the Society. While the true net value of this increase must be tempered with higher material and production costs, the percentage gain remains high and represents the effectiveness of our advertising solicitation.

The additional revenue from the *Journal* permitted a major, long-awaited and much-needed addition to *IMJ* production—the financing of a computer program now in operation for (a) mailing list preparation for the Publications Division, including the *Journal*, *Pulse* and *What Goes On In Illinois*; (b) market profile and research information for *Journal* advertisers and prospects; (c) the profiling of various physician categories now repeatedly requested by the advertising media; and (d) the opportunity for other divisions of the Society to computerize their programs as the need arises and their budgets permit.

At this point it may be well to state that the Society has *not* purchased, leased or rented a computer. Instead, only a master tape has been prepared, which is the property of the Society, and which can be used on any of the various makes of computers now in general use. As the need arises, computer "time" is rented to accomplish a project.

Thus far, the Business Services Division of the Society has made use of the tape by transferring two of its major and important functions onto the tape—dues billing and membership records. A marked increase of efficiency and accuracy has resulted. At the present time, changes, corrections, additions and deletions are made on at least a two-week schedule, which represents a 150-200 per cent improvement over the prior manual method.

Expenditure Justified

As with all major systems changes, the initial changeover cost has been substantial. However, it is anticipated that the annual maintenance cost will be no more, possibly less, than the previous method, with the added advantage of speed, accuracy, and Society-wide versatility. But if the expenditure must be justified, it can be for the following reasons alone:

(1) It is a long-term investment that has already proved its merit in improving dues-billing efficiency. This will be commented upon further in the report of the Secretary-Treasurer.

(2) The necessity to computerize the membership roster for mailing the *Journal*, *Pulse* and *What Goes On In Illinois* could no longer be delayed. The time had arrived when the U.S. Post Office Department refused to accept publications that had not been pre-sorted and bundled for zip code handling and distribution. This requirement became mandatory despite additional costs due to increased postal rates. To have accomplished such pre-sorting and zip code bundling on the addressograph plate system would have been very expensive and time-consuming. The addressograph plate system will still be maintained, however, for some membership mailings to county societies.

(3) The new computer service has made it possible for the *IMJ* to provide information about physician membership in Illinois to market-research divisions of pharmaceutical companies and media agencies—to justify use of the *Illinois Medical Journal* in their advertising plans. They have been asking for this information for a long time. It has not been available before. To the latest information available, the Illinois State Medical Society can now provide this service more completely than any other state medical society.

(4) Address changes can now be made promptly, assuring greater accuracy and efficiency in maintaining the membership mailing list.

The added income from *Journal* advertising has, in the opinion of this committee, also resulted in specific benefits to the members of the Society. It has given them better *Journals*. Among the outstanding issues published during the year were the April pre-convention number and the Reference Issue in October, the largest *Journal* ever published by the Society. In addition, more and better scientific articles have been published, as well as new features in the socio-economic field.

These are just a few of the "plusses" on the good side.

On the not-so-bright side of the ledger was the serious illness of Mr. John Kinney, Advertising and Business Manager of Publications, for several months in late '66 and early '67; and the loss of Mr. Al Boeck in July, 1967, to the American Society of Clinical Pathologists. We are pleased to report that Mr. Kinney has resumed his duties on a full-time basis and we wish Mr. Boeck a successful future in his new

administrative duties with the American Society of Clinical Pathologists.

In an attempt to predict a forecast for 1968 at this time (February, 1968), there are new and possible dark clouds on the horizon. Difficulties lie ahead for all medical publications with the issuance by the Federal Drug Administration of more new regulations regarding advertising and product information. There seems to be no end to this, and the over-all changes may result in a deleterious effect on advertising projection for the year.

Internal Revenue Service Ruling

To make matters even more confusing, the Internal Revenue Service has taken upon itself the prerogative of declaring that advertising income of non-profit organizations and societies, such as the Illinois State Medical Society, is subject to the same tax base as commercial, for-profit publications. The ruling is being contested in the courts and is under scrutiny by our own legal counsel. Unfortunately, the outcome cannot be predicted at this time. If the tax is imposed—and the IRS says it will be—it will make a considerable impact upon the earnings of the *IMJ* in '68.

On March 6, the *Illinois Medical Journal* was the host to key representatives of the advertising media and members of several drug companies at a meeting and reception in New York City. The purpose of the event was to enhance *IMJ's* relationship with these organizations and to extol the activities of the Illinois State Medical Society. At this meeting an audio-visual presentation of both the ISMS and the *IMJ* was given, and a society plaque presented to Dr. Ted Klumpp, President of Winthrop Laboratories, in recognition of his dedication to progress in the field of therapeutics in medicine and his loyalty to the purposes and activities of State Medical Societies in our nation.

Pulse, What Goes On

In retrospect, for the excellent year *IMJ* has had in 1967, the Journal Committee expresses its appreciation to the pharmaceutical firms that supported the *Journal*; to Roche Laboratories for its financial assistance in producing *Pulse*; and to Lederle Laboratories for *What Goes On In Illinois*. The latter two publications are supported by grants from these firms and cost the Society nothing from an expense standpoint. Each is considered an important addition to the Society's Communication and Public Relations projects.

The committee would be remiss if it did not comment upon the good work of Mr. Perry Smithers who did such a commendable job on all the publications during Mr. Kinney's illness and to thank Mr. Kinney for his consistent efforts to upgrade the *Journal*. A new member on the Publications staff, Mr. Richard Ott, came to the ISMS in late 1967. Mr. Ott has had 10 years of editorial and administrative responsibilities with an encyclopedia publishing firm in Chicago. His joining the staff was necessary following the resignation of Mr. Boeck. Miss Donna Mullen, a former receptionist, is now Mr. Kinney's secretary in the Publications Division, and is to be commended for her initiative and interest in the *IMJ*.

The Journal Committee has reviewed the comments concerning the *IMJ* in the 1966-67 Membership Survey and the recommendations made by the 1967 House of Delegates. Some of these have been implemented; others are in the process of activation.

The committee continues to strive for its previously stated goal, to make the *IMJ* the outstanding state medical journal of the nation, and invites constructive criticism and suggestions to accomplish this objective.

Jacob E. Reisch, *Chairman*
J. Ernest Breed James B. Hartney
Darrell H. Trumpe

Editorial Board

The Journal of the Illinois State Medical Society enjoys a unique distinction as one of the foremost State Society Medical Journals. There has been continuing increase in the number of scientific articles published, special science reports and symposia, "Medical Progress", editorials, and subjects of interest to the medical profession. The format of the Journal is most attractive.

At a recent meeting of the Editorial Board (Feb. 7, 1968) the Chairman of the Editorial Board drew attention to the Board of Trustees' directives regarding the Journal: "The Editorial Board should make recommendations to the Editor concerning the scientific content, regular features, subjects of special interest to the members. It should serve as a review board for manuscripts which the Editor believes requires special medical evaluation, and assist the Editor in any way possible to obtain and present manuscripts of the highest quality and maximum interest to physicians in Illinois".

Each member present at the meeting was in general agreement that there has been a steady improvement in the quality of the Journal, some were of the opinion that there were too many non-scientific articles and there were a goodly number who disagreed with this last comment. The Editor reported that the Journal has a good backlog of clinical articles on hand.

The Editor reported that there are various committees and organizations requesting space in the Journal and that the Editor is limited in the amount of scientific material he can schedule.

By official action, the Editorial Board voted to recommend to the Journal Committee and the Board of Trustees that:

"Because of the number of requests for space in the Illinois Medical Journal and because this space is limited by physical size of the publication and its revenues, it is suggested that the Board of Trustees refer committee reports and other organizational materials to the Editor and/or Editorial Board for publication at their discretion".

Further, it is recommended that: "Anyone or any group desiring to have a feature appear regularly in the Illinois Medical Journal, should prepare in advance at least four samples for evaluation by the Editor."

Examples of such regular features are reports on drugs and therapeutics, clinical pathological conferences, and articles from the Illinois Credit Managers Association.

It is further recommended that:

"Sponsors of symposia who expect to have papers published in the Illinois Medical Journal should be requested to notify the Editor well in advance that such papers will be forthcoming, that the papers be prepared for the consideration of the Editor and/or Editorial Board, and that the Journal Committee insist that some plan be included for

covering additional expenses involved with publishing such papers".

A suggestion that different colored papers be used for departmental material was considered a matter for the Journal Committee's decision; use of author's pictures, as recommended by the task force to study the opinion research survey and recently implemented by the Journal, was generally favored by the Board.

Samuel A. Levinson, *Chairman*
Edwin F. Hirsch Clarence J. Mueller
James H. Hutton Frederick Steigmann
Charles Mrazek E. Clinton Texter, Jr.
Arkell M. Vaughn

Editor Illinois Medical Journal

During the past 12 months a large backlog of articles for the Journal has been acquired, even though the average number of pages monthly has increased by eight.

There were 59 clinical articles published last year, representing at least one article in each specialty. The greatest number of articles, 15, dealt with Internal Medicine; other fields with more than one article were Surgery 5, Ophthalmology 4, Cardiology, Otolaryngology, OB-GYN, Pediatrics and Psychiatry 3, and Dermatology, Allergy, Anesthesiology, Neurology and Orthopedics 2.

In addition, in the past year seven medical progress articles and nine surgical grand rounds were published. Likewise, 17 editorials, 37 book reviews, 13 socio-economic articles, 17 excerpts, and 11 miscellaneous articles were included. The monthly message from the president, Dr. Leon Love's View Box, and Paul deHaen's Pharmaceutical Specialties were continuing features. Other special features were columns by the Drugs and Therapeutics Committee and by the Medicine and Religion Committee, and a monthly Blue Shield Newsletter.

A refinement in article presentation is the inclusion of an author photo and biographical sketch with each clinical article.

Your editor takes this opportunity to thank Messrs. Kinney, Smithers and Ott for their excellent cooperation and for their continuing interest in producing a publication of depth and stature.

T. R. Van Dellen

COMMITTEE TO STUDY OSTEOPATHIC PROBLEMS

This committee was appointed by the Board of Trustees on July 30, 1967, on recommendation of the ISMS Policy Committee. This recommendation was based upon (1) action taken by the AMA House of Delegates in June, 1967, regarding osteopathic graduates as follows: "Voluntary professional associations with a Doctor of Osteopathy should not be deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association" and (2) repeated inquiries from ISMS members as to their relationship with Doctors of Osteopathy in the care of patients.

The committee reviewed the activities of past committees of the Board of Trustees on this problem. They also investigated the activities of other states as to the relationship between Doctors of Os-

teopathy and Doctors of Medicine. On the basis of these studies, on Oct. 21, the committee prepared a recommendation for approval of the Board of Trustees and presentation to the House of Delegates as follows: "Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois."

A subsequent meeting of the committee was held with a similar committee of the Illinois Osteopathic Association. Much information was exchanged at this meeting which may be useful for future discussions.

William E. Adams, *Chairman*
George E. Giffin Frank J. Jirka Jr.
Willard C. Scrivner

POLICY COMMITTEE

No new policy statements recommended by the committee and passed by the Board of Trustees are available at this time. However, there are items to be considered by the committee at its next meeting, namely, (1) in order to be appointed as a member of an Illinois State Medical Society committee, a physician must be in good standing for the current year and (2) the Committee on Policy has been requested by the Board of Trustees to develop a statement relative to the type of financial information which should be furnished county medical society officers and members of the House of Delegates by the headquarters office during the interim between meetings of the House.

In addition, the Policy Committee is considering a number of policy statements developed by the Ohio State Medical Association Committee on Government Medical Care Programs and approved by its council which it may recommend to the Board of Trustees for referring to the House of Delegates.

William E. Adams, *Chairman*
Frank J. Jirka Jr. Paul P. Youngberg

COMMITTEE ON USUAL AND CUSTOMARY FEES

During the past year, the committee concerned itself primarily with problems arising from the 1967 usual and customary fee agreement between ISMS and the Illinois Department of Public Aid (IDPA).

Under the agreement—negotiated by this committee and approved by our Board of Trustees and House of Delegates—IDPA scrapped its physician fee schedule in favor of usual and customary fee payments for medical procedures to public aid patients.

Over a year has passed since the ISMS-IDPA agreement went into effect (Jan. 1, 1967). Has the plan proved successful? What are its strengths? Its weaknesses?

Strengths of IDPA Program

Looking at the bright side, the committee reports that IDPA payments to physicians for services to non-medicare patients almost doubled as a result of the agreement to pay usual and customary fees. Whereby ISMS physicians received \$3.7 million for IDPA services to non-medicare patients in 1966, they

received \$7.1 million in 1967. In addition, IDPA reports paying 94.2 per cent of all physician billings in 1967 (excluding combination Medicare-Public Aid patients). Hamilton and Hardin Counties rank highest in per cent of payments with IDPA paying over 99 per cent of billings, while Cook County reportedly received 96.5 per cent of their billings. Only five counties received less than 82 per cent of their total IDPA billings.

IDPA Delayed Payments

Unfortunately, the plan has several serious problems to overcome before it can be termed a complete success. The most serious of these problems is the unusually long delay in payments to participating physicians.

While part of the blame lies with IDPA itself for technical errors in the processing of claims, the most significant problem here presumably lies with physicians themselves. IDPA reports that 60 per cent of the delayed payments are the result of incomplete or erroneous information supplied on the claim form by physicians or their medical assistants.

Having reviewed many of the delayed bills himself, your committee chairman can attest to this fact.

Also to blame for delay in payments are: (1) individual coding of bills necessitated by the incomplete coding system of the AMA's Current Procedural Terminology; and (2) the complicated processing of bills involving Medicare patients covered by Public Aid.

How long should a physician have to wait for payment from IDPA? The average claim form—if properly completed—should take about 40 days to process. If a physician has not received payment within 60 days after filing it, he should write to Mr. Robert Wessel, Chief of Medical Administration, IDPA and give him all pertinent information. In any event, physicians are urged *not* to rebill—it will only result in further delay and confusion.

IDPA Fee Adjustment

Another common complaint has been that some physicians are not receiving their usual and customary fees from IDPA. In many cases, fee adjustments on physicians' bills are the result of incomplete information supplied by the physician . . . or a misunderstanding on the part of IDPA.

In any case, a physician's first appeal should be to the IDPA's Springfield office. If the physician and the IDPA cannot agree, the physician has the right to appeal to his county medical society and eventually the state medical society.

Insufficient MD Participation

Another serious problem is the insufficient number of physician participants in the program.

Of the 3,600 physicians treating IDPA patients, only 944 are Chicago physicians. This means that—while 88 percent of our downstate members accept IDPA patients—only 15 percent of our Chicago members accept them. The result is only a handful of doctors treat the majority of recipients. And the greatest share of Public Aid patients are being treated by only 94 physicians who—according to IDPA—receive almost half of the total public aid medical payments made throughout the state. Unless we convince more Chicago doctors to accept Public Aid patients, we may be in trouble. For if

this program is to succeed, we will have to double the number of participating physicians in the next few years.

After reviewing hundreds of criticisms, reports and inquiries on the IDPA program, your committee is confident the usual and customary fee plan can and will succeed. To succeed, however, we need your co-operation in charging and accepting only your usual and customary fees.

For the time being, therefore, we urge you not to escalate your fees to IDPA patients. For our agreement with IDPA calls for cost of living increases at two year intervals—since this is the period of time covered by each legislative appropriation. The next budget goes into effect in 1969.

Medical Fee Plan of DVR

The committee also met with the Division of Vocational Rehabilitation to request several modifications of its newly-developed Medical Fee Plan. We are pleased to report that DVR took our recommendations under advisement and agreed to the following changes. (1) Its original medical fee ceilings of \$500 and \$1,000 on single and multiple-stage surgery have been eliminated and the basic concept of reasonableness has been applied as it is to all procedures. (2) It has also agreed to seek prior mutual agreement with physicians and surgeons on fees, and put this estimated fee on its authorization form. The estimated fee, however, will be subject to adjustment if the post-operative report or treatment report shows justification.

Department of Children & Family Services

The Department of Children and Family Services also reports that it is now paying usual and customary fees to physicians for the care of children under its custody. These include mainly children in foster homes and institutions, cases of suspected child abuse and unwed mothers. Many of its children are eligible for Public Aid and these bills will be paid by the Department of Public Aid. Other medical bills are paid directly by this department. It also recognizes the county medical society's review committee. In cases where the physician disputes a bill, the Department will recognize his right to request a review, if it cannot be adjusted by the Department.

Illinois Blue Shield

At the 1967 annual meeting, the ISMS House of Delegates approved support of a proposal from the Blue Shield Plan of Illinois Medical Service to pay the usual and customary fees of physicians who treat Illinois steelworkers and their families.

The committee is pleased to report that the Blue Shield plan—effective Aug. 1, 1967—apparently has been successful and popular with the physicians. In any event, we have not received a single formal complaint about the program.

The preceding is merely a report of progress and requires no action.

Philip G. Thomsen, *Chairman*

Carl E. Clark

Frank J. Jirka

Mather Pfeiffenberger

Warren W. Young

Annual President's Dinner

6:30 p.m.
Tuesday, May 21
Bal Tabarin
Sherman House
Chicago

\$7.50

Both dinner and evening party
available on a single ticket on
sale in convention registration
area

\$12.50

MEXICAN

FIESTA

9 p.m.
Tuesday, May 21
Grand Ballroom
Sherman House
Chicago

\$7.50



Finances and Budgets

SECRETARY-TREASURER

House of Delegates Minutes

The most important actions that take place within the organizational walls of this society occur within a few hours each year during the three sessions of the House of Delegates. At this time, major proposals for coping with evolutionary changes in the ever-expanding complexities of providing medical care are presented, studied, discussed and voted upon. Out of a series of committee reports and ballots grows the form of ISMS policy for one more year. The over-all medical practice environment of tens of thousands of physicians and millions of patients are thus changed, for good—or for ill.

To insure accuracy of the actions of the House of Delegates a complete stenographic record of each House session is obtained. As Secretary-Treasurer of the Society, I have reviewed this transcript to verify its accuracy and completeness. Any society member who also wishes to review this record may do so upon request to the Secretary-Treasurer or the Executive Administrator. As a point of interest, the 1967 verbatim report consists of 450 pages.

In order to assist the delegates in making the major actions of the 1967 House quickly known to all members of the society, an edited resume was mailed to each delegate within one week following the meeting. The June, 1967, issue of the *Illinois Medical Journal* contained this same abstract for study by

each ISMS member. The same procedure is scheduled for the 1968 meeting.

The directives of the 1967 House of Delegates were arranged into a sequence of assignments for the Board of Trustees and staff so that implementation could be carried out in an efficient and methodical manner. Considerable time has been spent during the year at each Board meeting reviewing the current status of each item. Complete fulfillment of each request for action by the House has now been accomplished, and will be reported in greater detail by the Chairman of the Board of Trustees.

Dues Billing Procedures

Two years ago the Illinois State Medical Society initiated a new service feature for the members of the society and of special benefit to the Secretary-Treasurers of the component societies who desired it—dues billing and collection from the State office. It is with pride that I can report that the *Illinois State Medical Society* is still the only state medical society that offers its county societies the service of direct billing and collection of all annual membership dues.

Admittedly, there were delays and inaccuracies in the 1966 effort and the experience gained in the 1966 program was put to good use in 1967. However, the results obtained in both 1966 and 1967 for dues

billing and collecting, as well as in many other modalities of service needed to effectively and efficiently serve the membership, revealed that the current punch card system then in use was outmoded, ineffective, limited in scope and subject to inaccuracies. In addition, the *Illinois Medical Journal*, *Pulse*, and *What Goes On In Illinois* were at this same time in need of additional facilities in order to comply with the new postal regulations starting Jan. 1, 1968, concerning pre-sorting and bundling for zip code handling.

Therefore, late in 1967, the Business Services Division with Board of Trustees approval, designed and converted the old-style punch card file to a high speed "third generation" magnetic tape system. The information currently on tape is that essential for the *Illinois Medical Journal* and the Business Services Division. Included as biographic information for each ISMS member are the following:

- Medical education identification number
- Name and address
- Practice and specialty data
- County, ISMS and AMA membership status
- Current year dues payment data
- IMPAC (voluntary payment) status
- Prior year (2) membership data
- Specialty board and society data
- Intern and residency data
- Provision for two additional addresses for special mailing requirements
- Citizenship status
- Birth date and sex

A truly effective membership information system is now in use at the ISMS. All information processing requirements for the society will now revolve around this single data base. The access to each physician record within the Data file is through the physician's AMA Medical Education Number (M.E. #). This provision gives a unique number access ability in addition to following the pattern already established in the computer processing section of the American Medical Association. The Data file will also accommodate non-physician data for special mailing purposes, i.e., county society auxiliary lists, medical assistants, hospitals, etc. Accuracy and currency of information will also be accomplished, since present plans provide for correcting and up-dating the tape at two-week intervals.

The initiation of the ISMS data processing facility, as suggested by the 1967 Reference Committee on the Opinion Research Report, was managed with a minimum expenditure of general funds through substantial assistance from the *Illinois Medical Journal* and the co-operation of the AMA's computer department. AMA employees gave substantial advice and guidance, lending the advantage of their many years experience with data processing.

In 1968, 70 county medical societies used the ISMS direct membership dues billing and collection service, compared with 55 in 1967. This increase of 27 per cent is a true expression of the value of this kind of service to the county society officer who does not have a lay secretary or staff to handle this routine and burdensome chore. With no increase in staff, ISMS has been able to provide this centralized service that is not duplicated in any other state society.

In addition to its use for the 1968 dues billing, the computerized Data file has already proved its value in the preparing of mailing labels for the

Illinois Medical Journal, *Pulse* and *What Goes On*. These are now prepared at a fraction of the previous cost. The new postal requirements for zip code sorting and national zone counting could not have been met with the outmoded addressograph plate system without a large additional cost for time-consuming and ineffective manual labor.

The data file now in use is by no means limited to usage by the *IMJ* and the Business Service Division. As time goes on, it can well become an all-purpose Society tape, since only approximately one-third of the tape's space potentialities have thus far been used. Other divisions of the society, as the need arises and as the budget permits, may add data on the tape.

At this time it might be well to reiterate a statement made in the Report of the Journal Committee—that the society has *not* purchased, leased or rented a computer. Our needs would not justify this. Instead, only a master tape has been prepared, which is the property of the Society, and which can be used on any of the various makes of computers now in general use. As the need arises, computer "time" is rented to accomplish a project.

Leadership Conference

The 1967 Leadership Conference was held in Springfield on April 15 and 16. One of Illinois' great leaders, W. Russell Arrington, State Senate President Pro Tempore, was in attendance and spoke at the wrap-up luncheon. Special guest at the Saturday evening dinner was Bill Veeck. His sophisticated brand of homespun humor was a nice change-of-pace from the serious matters of the formal conference program.

Unfortunately, attendance at this conference was not as large as was anticipated. A survey made from each member in attendance as to suggested type of meeting, length of meeting, time of holding as to day of week and time of year, was very inconclusive and no general consensus could be deduced.

For 1968 an entirely new format is planned. Top level speakers, subjects current and varied enough to appeal to all elements of the profession, and a change to a one-day meeting *should* improve attendance. Comprehensive health planning, medical manpower shortages and national political issues are to be discussed by top experts in those fields. Among the national figures on the program are four U.S. Congressmen for Illinois; Dwight Wilbur, M.D., President-Elect of the AMA; Robert Novak, Washington columnist and co-author of the book "LBJ—The Exercise of Power"; and U.S. Senate Minority Leader Everett McKinley Dirksen. State Medical Society officers and other leaders in Illinois medicine are to supplement the program.

While this conference is designed primarily for county society officers, delegates, members of the Legislative and Public Affairs Committees, all members of the Society are urged to attend. In addition, because of the current importance of the program, this year's meeting is to be opened to other professional groups.

Journal's Tax Status

The Internal Revenue Service issued regulations on Dec. 12, 1967, imposing in 1968 an unrelated business income tax on the advertising revenues earned by publications of non-profit organizations.

The 48 per cent corporate income tax will be levied against advertising revenue over and above that needed to operate the publications involved. IRS imposed by regulation this new concept based on a 1950 law dealing with "unrelated" income of tax-exempt organizations.

The effect of this tax on the ISMS budget will not be fully known until the completion of the 1968 fiscal year. Its potential cost could be most severe and unanticipated. The ISMS Journal Committee, Business Division and Legal Counsel are now studying the *Journal's* financial structure in order to define just what, if any, our potential liability might be.

Several medical publications have indicated that they intend to take the regulations "to court" to test their validity. There is a good chance that court tests would rule the regulations invalid, being in conflict with the law they are intended to administer. There is also the possibility that the Treasury will go along with a law that would provide for a less than full corporate tax on non-profit publication advertising revenues.

I call this to your attention at this time for there is the possibility that the imposition of this tax may considerably alter the projected budget and financial statement for 1968. Variations in *IMJ* advertising income, changing production costs and the possible tax liability make it impossible to project the 1968 final figure in this segment of the budget with any degree of accuracy at this time.

In the meantime, ISMS will maintain a careful watch over (1) the potential effect of this tax upon our total budget and (2) efforts throughout the association community to restrict or eliminate the tax altogether.

Membership Statistics

Changes in membership statistics over the past several years are indicated in the accompanying table.

As in the past, there are a number of physicians in Illinois who are not members of this Society. The Membership Committee has repeatedly reviewed and studied this situation and have made several recommendations.

At their request, early in 1968, a listing of non-member physicians in each county medical society was provided by the Headquarters Office to the District Trustee for use in a joint recruitment cam-

paign with each county society. Although the majority of the non-member physicians in Illinois are interns and residents in Cook County, there are still a number of non-members in both Cook County and the downstate portion of Illinois. County medical societies are urged to invite all eligible, ethical physicians to participate in the values and benefits of their key medical organizations—the local society, ISMS and the American Medical Association.

Although there are many specialty societies and hospital staffs that call for the individual physician's allegiance, time and financial support, there must be one organization to represent *all* physicians throughout the state and nation. Illinois doctors, when called upon, must speak with one voice on issues that arise in the course of distributing health care.

Financial Statements for 1967

Condensed financial statements are presented here for the benefit of the membership. The complete audit report from the firm of Peat, Marwick, Mitchell & Co. will be given to each member of the House of Delegates during the Annual Convention. This is, of course, available for review by any member upon request to the Headquarters Office. Copies of the 1968 and 1969 Operating Budget are to be provided to the Delegates in advance of the Annual Convention, so that they might review the Society's financial position, results of operations, and future planning well before the actual Reference Committee hearings.

As stated in previous reports, it should be noted that the 1968 and 1969 budgets are in balance and do not include funds for any new projects. *Should the House of Delegates direct any new programs of a major nature, an accompanying method of providing the necessary finances for them should be provided by the House at the same time.*

The past year has been both a challenging and successful one for the Illinois State Medical Society. It has been an active one for many individuals, groups and committees. The reports contained in this issue attest their accomplishments and serve as a fitting testimonial to each individual's interest. Special acknowledgement should be made of the new form of leadership of Dr. Newton DuPuy as President, who, with President-Elect Dr. Philip G. Thomsen, successfully presented the policies and

	1967	1966	1965	1964	1963	1962
Membership as of January 1.....	10,607	10,626	10,500	10,145	10,101	10,185
New Members	515	517	492	537	429	376
Reinstatements	43	65	43	211	59	72
Total added	558	582	535	748	488	448
Dropped during the year:						
Died	211	191	172	175	176	186
Moved from State.....	151	172	101	47	60	160
Resigned	12	21	28	7	6	9
Nonpayment	223	217	108	164	202	177
Total dropped	597	601	409	393	444	532
Membership as of December 31.....	10,568	10,607	10,626	10,500	10,145	10,101
Regular	9,335	9,417	9,429	9,412	9,097	9,056
Residents	214	250	278	230	223	254
Service	59	51	26	30	13	15
Emeritus	514	484	494	459	467	446
Retired	399	349	334	312	328	310
Hardship	47	52	45	31	17	20
Intern		4	20	26		
Total	10,568	10,607	10,626	10,500	10,145	10,101

activities of the Society in many areas of the State. To those behind the scenes—the faithful staff—who have consistently worked for the betterment of the Society, a grateful word of sincere appreciation is due. They, too, have become specialists in their fields and have worked diligently to elevate the progressiveness of the Society. The Illinois State Medical Society can well be proud of its stature among other state medical societies, thanks to the forward vision, initiative and plain hard work of many—both physicians and staff.

Jacob E. Reisch

Sub-Committee On Benevolence

The list of beneficiaries remained the same as in the previous year, with exception of one physician who died during the year.

All beneficiaries were sent the customary form for evaluation with their names typed in and were requested to sign it noting only any changes in their financial status. These have all been returned and examined.

One widow who has a job was awarded a small amount as she had two minor children at the time the grant was made (1958). She still is employed and the children, ages 25 and 27, are no longer minors. One of them is living in Germany.

After giving this careful consideration it was decided to withdraw the grant.

The financial status of the Benevolence Fund appears elsewhere in this handbook.

Keith H. Frankhauser, *Chairman*

William M. Lees Raleigh C. Oldfield (deceased)

Mrs. Sherman C. Arnold, *Auxiliary Representative*

Illinois State Medical Society Position Statement—Dec. 31, 1967

ASSETS	Operating Fund	Benevolence Fund	Permanent Reserve Fund	Property Fund	Student Loan Fund	Suppl. Empl. Retirement Fund
Cash	\$153,129	\$ 23,366	\$ 66,946	\$ 10,248	\$ 4,496	\$ 23,030
Receivables	32,976				3,275	
Investments, at cost	149,965	149,219	172,321		37,500	
Student loans					65,752	
Prepayments and advances	7,973					
Office furniture and fixtures				84,447		
Interfund Receivables (payables)	(145,442)	64,526	77,210	3,706		
Total Assets	\$198,601	\$237,111	\$316,477	\$ 98,401	\$111,023	\$ 23,030
LIABILITIES AND FUND BALANCES						
Payables	\$ 70,677					
Accrued expenses	47,489					
Deferred income	24,188	2,233	2,552			
Fund Balances	56,247	234,878	313,925	98,401	111,023	23,030
Total Liabilities and Fund Balances	\$198,601	\$237,111	\$316,477	\$ 98,401	\$111,023	\$ 23,030

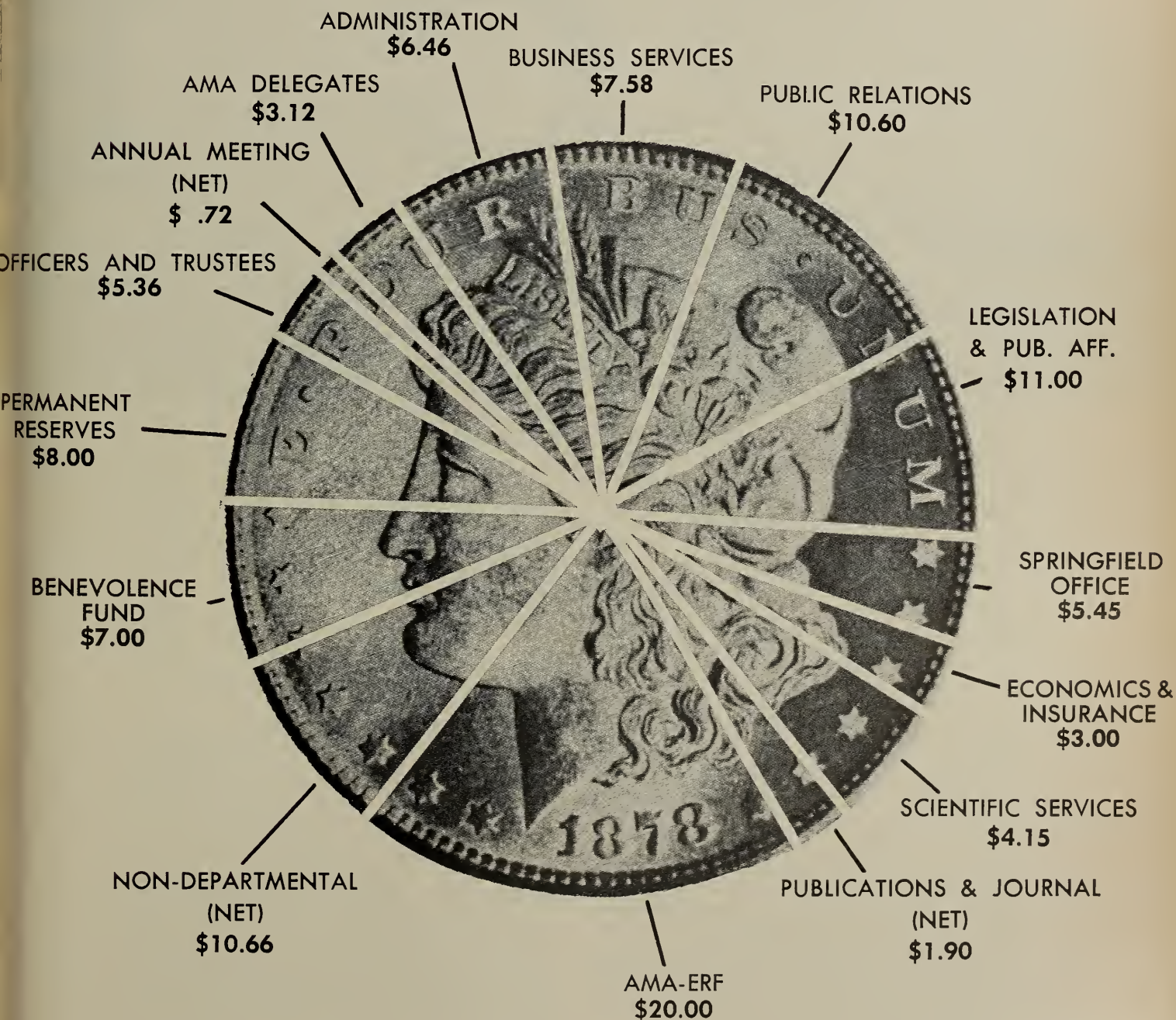
Income Statement—Operating Fund—Year Ended Dec. 31, 1967

INCOME		EXPENSES	
Membership dues—		Board and Officers	\$ 36,177
Basic dues—\$105 per member	\$980,326	ISMS Meeting	28,248
Less Allocations:		AMA Meetings	22,163
AMA-ERF—\$18 per member	167,980	Administration	72,959
HCCI—\$2 per member	18,665	Business Services	109,614
Benevolence Fund—		Public Relations & Economics	96,619
\$7 per member	65,326	Economics & Insurance	14,526
Permanent Reserves—		Legislation & Public Affairs	95,666
\$8 per member	74,658	Springfield Office	50,541
Contingency Reserves—		Publications & Scientific Services	41,626
\$1 per member	9,332	Illinois Medical Journal & Publ.	251,479
Total allocations	335,961	Non-Departmental	84,822
Net membership dues	644,365		
Illinois Medical Journal	149,140	TOTAL EXPENSES	\$904,440
"PULSE" and "WHAT GOES ON"	42,900	EXCESS OF EXPENSES OVER INCOME	\$ 763
Annual Convention exhibits	16,364		
Interest and dividends	15,336		
All other	35,572		
TOTAL INCOME	\$903,677		

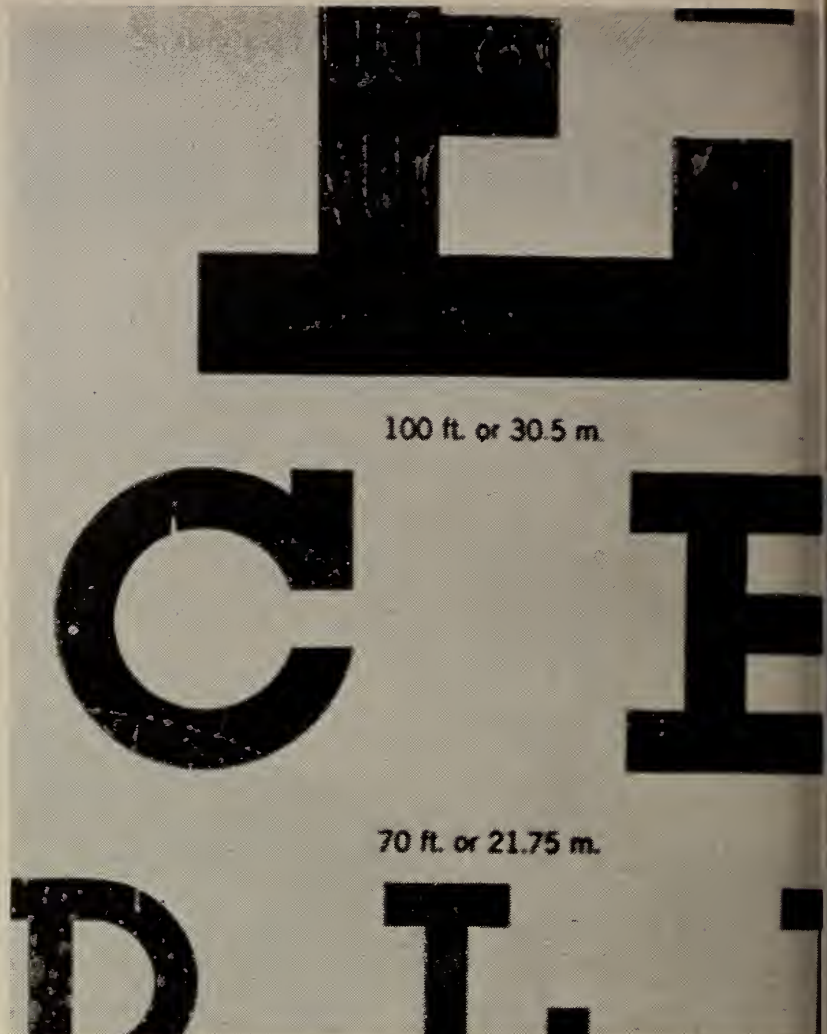
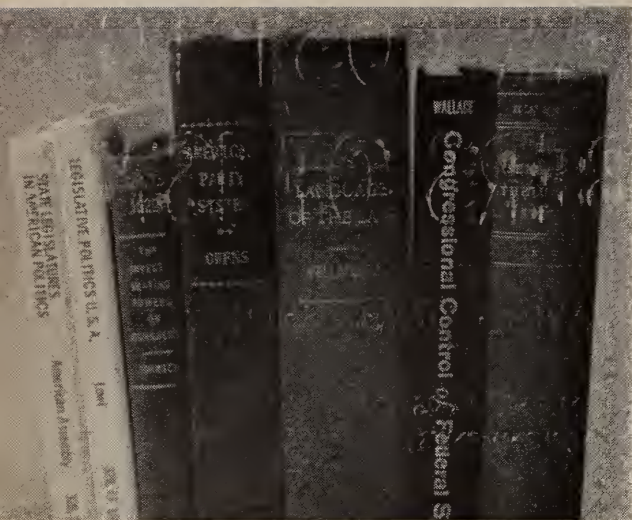
1968 DUES DOLLAR COST TO INDIVIDUAL MEMBERS OF ISMS

(FIGURES BASED ON 9,450 DUES PAYING MEMBERSHIP)

(INDIVIDUAL SECTION GROUPINGS ON THE BASIS OF
CURRENT FISCAL RESPONSIBILITY ASSIGNMENTS)



TOTAL 1968 REGULAR MEMBER'S DUES: \$105.00



Judicial Council

The Judicial Council has not had a formal meeting this year inasmuch as no controversies have arisen which we, under the Bylaws, should consider. The following committee reports are submitted:

ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee had no meetings during the past year. The committee acts only on cases referred to it from the component societies; no cases have been referred thus far.

At the present time, the Bylaws contain two statements of definite variance with each other and these should be reconciled.

Chapter IX, Section 4A 1 states: "that the Judicial Council acts as the Ethical Relations Committee of the Society."

Chapter XII, Part 2, Section 7 states: "that the Board of Trustees shall appoint from its members, an Ethical Relations Committee to review matters involving the interpretation of the Principles of Medical Ethics, violations of the Constitution & Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society. It shall serve as an appellate body to review cases involving these matters referred by component medical societies, and shall consider matters of law (ethics) and procedure."

Item 1, under Section 4A of Chapter IX should be eliminated and the statement in Chapter XII, Part 2, Section 7 should remain. This matter has been referred by the Board of Trustees to the Committee on Constitution & Bylaws for reconciliation.

The committee wishes to congratulate the House of Delegates for approving the recommendations of the Committee on Constitution & Bylaws which provided the updated procedures in the conduct of the committee's activities.

Willard C. Scrivner, *Chairman*

J. Ernest Breed

George E. Giffin

William M. Lees

IMPARTIAL MEDICAL TESTIMONY

State Financing of IMT. When the IMT program was begun in the Illinois Circuit Court, the costs were to be paid by the Illinois State Bar Foundation, which was the custodian and disbursing agent of a special fund made possible by grants from the Ford, Wieboldt, Deere, Woods and Lilly Foundations. The

original grant was for two years, after which time the State of Illinois, if the program proved to be a success, was to assume the responsibility of financing. The state delayed assuming the financing of the program; however, the Ford Foundation extended its grant until July 1, 1967.

The permanence and success of the program is now assured. The necessary monies have been included in the regular court budget as of July 1, 1967. An amount of \$12,000 has been allotted for the biennium beginning July 1, 1967.

A final report has been made to the Ford Foundation, and the Administrative Office of the Illinois Courts has directed the Illinois Bar Foundation to return to the Ford Foundation any unused funds which had been allocated to the program.

Use of IMT—Illinois Circuit Court. During the year 1967, the number of IMT examinations ordered in the Illinois Circuit Court reached 60. The total for 1966 was 59. This would indicate a "leveling off" period. During previous years, the number of examinations almost doubled from one year to the next, although the total was much lower.

Use of IMT—Federal Court. The number of cases in which an IMT examiner was used in Federal Court during 1967 was 20. This is comparable to the number of cases in previous years. Although small in number, the use of these examinations was made in important and difficult cases, most often leading to settlement.

Change in Supreme Court Rule. The Supreme Court revised its rules as of Jan. 1, 1967. Rule 17-2, the Impartial Medical Testimony Rule, has been rewritten and is now Rule 215(d). It is substantially the same as the previous rule. However, under the previous rule, IMT examinations were limited to personal injury cases, and under the new rule, an examination may be ordered in any "proper" case. During 1967, only in one non-personal injury case was an IMT examination ordered. A psychiatric examination was ordered in a divorce case to determine the fitness of the mother for child custody purposes.

The other change in the rules removed the limitation restricting the use of IMT examinations to the pre-trial stage. Virtually all IMT examinations, however, continue to be ordered during the pre-trial stage of the lawsuits.

Clinton L. Compere, *Chairman*

R. Gregory Green Jerome J. McCullough

Maurice D. Murfin

COMMITTEE ON QUACKERY

The Committee on Quackery, as a result of several legislative developments, has now been given additional opportunities to restrict the illegal practice of medicine and to co-operate with the legal authorities in providing information concerning violations of the law.

During the 75th General Assembly, House Bill 2432 was signed into law by Governor Kerner. This new law created a Division of Professional Supervision in the Department of Registration and Education which is concerned exclusively with enforcement of the "Illinois Architectural Act"; "The Illinois Dental Practice Act"; "The Illinois Medical

Practice Act"; "The Illinois Professional Engineering Act"; "The Illinois Structural Engineering Act"; "The Illinois Public Accounting Act"; and "The Illinois Veterinary Medicine Practice Act."

The newly created division has a biennial budget of \$150,000 and is responsible for the supervision and co-ordination of all enforcement activities involving the named acts, including necessary investigations, charges and complaints, initiating prosecutions, administrative actions, and civil remedies and related activities.

On Aug. 15, 1967, Department Director, John C. Watson, named Mr. Frank R. Petrone Co-ordinator of the Division of Profession Supervision.

Mr. Petrone is extremely well-qualified for this position. He has worked closely with the Committee on Quackery in the past and is planning to maintain close communication between the division and the professions involved.

The committee reports that with the enactment of Senate Bill 954 chiropractors and others licensed under the Medical Practice Act will no longer be permitted to perform school examinations for purposes of Section 27-8. Senate Bill 954 amends the School Code so that only a physician licensed to practice medicine in all its branches may now make such an examination.

Also passed during the 75th General Assembly was House Bill 145 which amended the Medical Practice Act by providing that licensees under the Medical Practice Act may not engage in unprofessional advertising. Listings in public print, in professional and telephone directories, or announcements of change of place of business, may not be made in bold face type.

The Committee on Quackery has concerned itself with the problem presented by the Superintendent of Education's authorization of the National College of Chiropractic to grant a Bachelor of Science degree. A petition of the Illinois Medical Society alleging that the National College is not qualified to grant a Bachelor of Science, has been filed with the Superintendent of Education. As a result, the matter has been reopened and the National College has been notified to answer the petition of the Illinois State Medical Society.

The Committee on Quackery seeks the co-operation of every physician in the State of Illinois in reporting information concerning the unauthorized practice of medicine, and unprofessional advertising, and stands ready to assist Illinois enforcing agencies to implement the law.

Edward A. Piszczek, *Chairman*

Robert F. Bates

John S. Kapernick

Mladen Mijanovich

Raymond B. Murphy

Elliot Parker

William Parker

William B. Rich

Simon Y. Saltman

T. R. Van Dellen

Wilson H. West

The progress report from the Impartial Medical Testimony Committee was presented to the Board of Trustees of ISMS at the January meeting by Dr. Shaw for the committee.

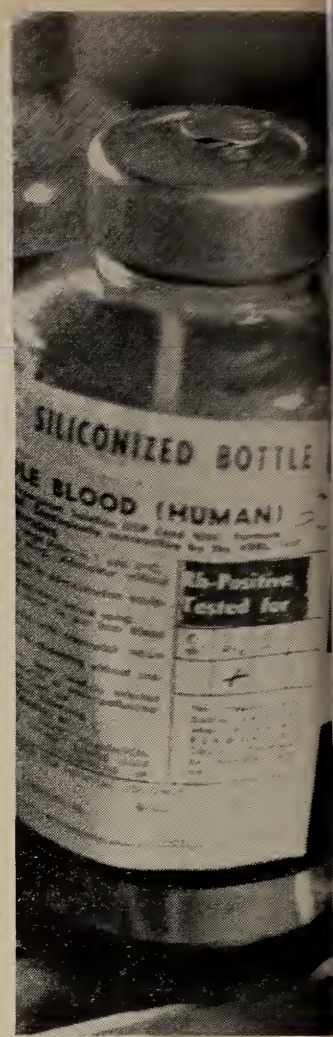
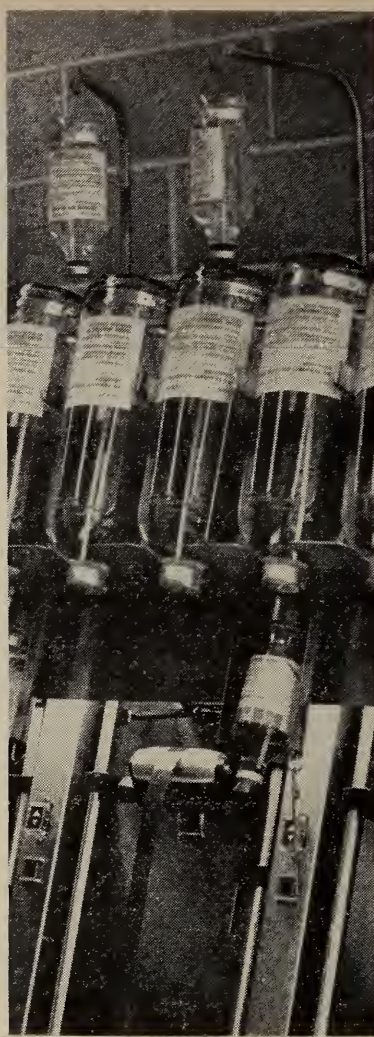
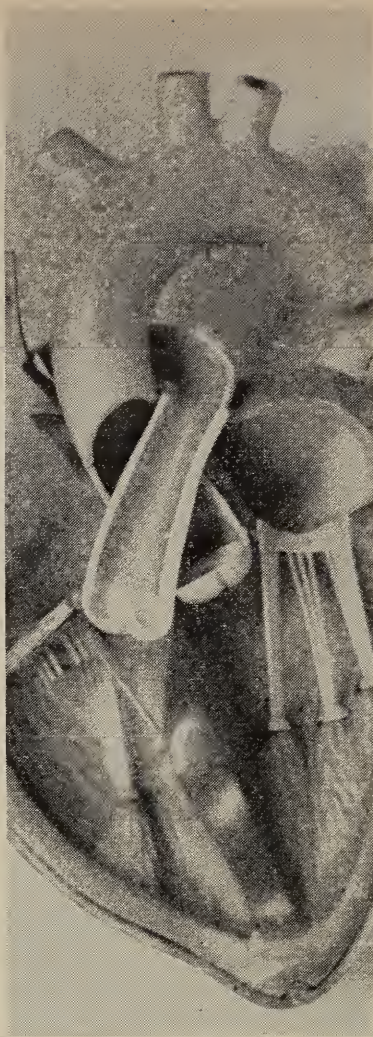
The report of the Judicial Council and its committees is respectfully submitted:

Noel G. Shaw, *Chairman*

Clinton Compere

Edward A. Piszczek

William H. Walton



Council on Legislation & Public Affairs

The Council on Legislation and Public Affairs has met three times since the last meeting of the House of Delegates. At least one additional meeting will be held prior to the Annual Meeting. Following each meeting, the council has reported in detail to the Board of Trustees on all important legislative matters, both state and federal. County society officers, delegates, and other key leaders have been advised of developments as they have occurred through the Council's special publication "On the Legislative Scene", the *Illinois Medical Journal* and *Pulse*. Federal legislation is reported currently to the membership through the *AMA News* and other media.

Federal Legislation

Fortunately, the 90th Congress, which opened its first session in January, 1967, saw a markedly reduced tempo of health legislation over that prevailing in the 89th Congress. The two most significant health measures passed to date in the 90th Congress, are H.R. 12080 (Social Security Amendments of 1967) and H.R. 6418 (Partnership for Health Amendments of 1967). Details of the changes in the Medicare and Medicaid Programs brought about by H.R. 12080 (PL 90-248) have been widely reported and are not being repeated in this report. For the most part, the changes were in accordance with the recommendations of medicine. Hopefully, they will result in better administration of the Medicare and Medicaid Programs.

The passage of H.R. 6418 (PL 90-174) establishes and funds comprehensive health planning on a permanent basis. The law provides for regional planning as well as a state-wide plan of facilities and services. The plans developed under this program will control federal and state allocations in the health-care field and may have far-reaching effects on non-governmental facilities and services. The law also abolishes the categorical grants for public health services and permits the states to determine the specific uses of federal funds which are now awarded to the states as a lump sum. In Illinois, the Department of Public Health has been designated as the agency to administer this act.

Medicine was unsuccessful in its recommendation that the law should specify the type of public health services for which governmental funds may be utilized. It will therefore be necessary to give increased guidance to our public health officials in the development of adequate and appropriate services.

Comprehensive Planning introduces a new area of governmental activity. Mandatory planning will replace the voluntary planning with which medicine has co-operated heretofore. Although the law provides that the majority of members of the planning committees must be consumers of health care, there are opportunities for physician leadership, particularly in the early stages when the planning groups are being formed. Your Council believes that the medical profession should take the initiative in es-

establishing these planning groups on a sound footing and has so recommended to the Board of Trustees. With the Board's approval, an Ad Hoc Committee on Planning has been established with representatives of the various Councils within the Society having an interest in this subject. The Ad Hoc Committee will maintain up to date information on the implementation of this law and otherwise assist the

county medical societies in taking an active role in the various regional planning groups.

Numerous federal bills of medical significance remain under consideration in the second session of the 90th Congress. The following listing gives a brief description and the status of some of the more important health measures as of the end of February.

Bill No.		Status
H.R. 5315	<i>Tax Status of Professional Corporations:</i> Allows corporate tax treatment for MDs forming professional associations.	Pending in the House
H.R. 6165	<i>National Medical Devices Standards Commission Act:</i> Establishes a national commission to study medical devices and recommend methods of federal regulation.	Pending in the House
H.R. 8765	<i>Tax Treatment of Income from Publications of Tax-Exempt Organizations:</i> Excludes income derived from publications (advertising, etc.) of tax exempt organizations.	Pending in the House
H.R. 10726	<i>Medical Devices Safety Act of 1967:</i> FDA pre-marketing clearance of certain therapeutic materials and medical devices.	Pending in the House
H.R. 10790	<i>Radiation Control Act of 1967:</i> Provides for development of program of control and regulation of radiation hazards. (Hearings also held by Senate Commerce Committee on a similar bill—S. 2067)	House hearings held
H.R. 13096	<i>Extension of Diploma Nurse Training Program:</i> Provides increased assistance to diploma schools of nursing.	Pending in the House
H.R. 13168	<i>Humane Laboratory Animal Treatment Act of 1967:</i> Expands present federal regulation of animals in research.	Pending in the House
H.R. 14816	<i>Occupational Safety and Health Act:</i> Would establish mandatory occupational safety and health standards.	House hearings called
H.R. 15281	<i>Community Mental Health Centers Act Amendments:</i> Would expand present law to permit the treatment and rehabilitation of alcoholics and narcotic addicts.	Pending in the House
H.J. Res 939	<i>Establishment of Joint Committee on the Cost of Medical Care:</i> Establishes a House-Senate Joint Committee on Cost of Medical Care.	Pending in the House
S. 260	<i>Medical Restraint of Trade Act:</i> Prohibits physicians from dispensing eyeglasses; owning pharmacies, drug repackaging firms.	Senate hearings held
S. 513	<i>Adult Health Protection Act of 1967:</i> Would establish health protection centers. Provides physical exams for persons over 50.	Pending in the Senate
S. 628	<i>Blood Banks Exempted from Antitrust Laws:</i> Exempts non-profit blood banks from antitrust laws.	Senate hearings held
S. 2251	<i>Hill-Burton Extension and Hospital Modernization:</i> Continues Hill-Burton program with emphasis on hospital modernization.	Pending in the Senate
S. 2882	<i>Artificial Organs, Transplantation and Technological Development Act:</i> Establishes a Commission on Transplantation and Artificial Organs.	Senate hearings called
S. 2893	<i>Liberalize Medicaid Formula:</i> Would liberalize the formula under which Federal aid is provided under the Medicaid program.	Pending in the Senate
S. 2936	<i>Drugs Under Part B of Medicare:</i> Would include certain drugs as benefits under part "B" of Medicare.	Pending in the Senate
S. 2944	<i>Drug Compendium:</i> Authorizes the establishment of a Federal Drug Compendium by FDA.	Pending in the Senate

It is difficult to determine at this point which, if any, of these measures will be acted upon. Among the items most likely to receive attention are further control of the use of animals in research, pre-marketing approval of medical devices, and the addition of drugs to Medicare.

During the year, the Internal Revenue Service decided to change its rules and to tax the income of medical journals and other publications of not-for-profit organizations. Several bills have been introduced in Congress to block this move by IRS. Your council has co-operated with the AMA Legislative Department in an effort to pass this type of legislation but the prospects are not hopeful. An alternative would be for these organizations to take legal

action against the ruling. The effects of the ruling on income from our own *Illinois Medical Journal* will likely be covered in the report of the Journal Committee.

Your council continues to be concerned about the trend to widen the scope of services of existing governmental health care programs and to add new ones. We are particularly concerned about the demands for investigation of physicians' fees under Medicare and Medicaid. These investigations may well lead to a serious attempt to regulate fees. We are also concerned with the government's move to promote prepaid group plans which would remove free choice of physician.

State Legislation

Your council reported to you in considerable detail at the 1967 House of Delegates on the many items of state legislation involved in the 75th Illinois General Assembly which was then in the closing stages of its regular session. The regular session concluded on June 30, with no adverse results except for the confusion over taxes. Your council and the society's officers and trustees were very much in the forefront in preventing a general tax on medical services during the final mad scramble to enact new tax bills. As finally worked out, a tax was intended on drugs dispensed by pharmacists but not physicians. Despite the clear wording in the law, the Revenue Director then ruled that drugs dispensed by physicians were taxable. This move was countered when ISMS Legal Counsel obtained a temporary injunction restraining the Director of Revenue from enforcing this rule. As things now stand, physicians have the option of collecting and paying the tax under protest or ignoring the ruling entirely. Physicians who follow the latter course may eventually be assessed for the amount of the tax plus a penalty if the injunction is eventually overturned. On a final note of confusion, the entire tax package has been declared unconstitutional and the matter must be decided by the State Supreme Court.

Meanwhile, the 75th General Assembly continues to meet in a series of adjourned sessions. The field is wide open for the introduction of new bills. Among those submitted is one which would remove the Service Occupation Tax from all drugs. In the controversy over the taxing of drugs, the pharmacists have taken a position that the tax should apply to dispensing physicians if it applies to other dispensed drugs. Upon the recommendation of your council, the Board of Trustees has adopted the following position:

That the Illinois State Medical Society is opposed to a Service Occupation Tax on drugs whether dispensed by a physician or a pharmacist.

Your Council requests the House of Delegates to concur in this position.

A number of additional measures of medical significance remain active in the adjourned sessions. Among these is a bill to establish a commission to study hospital costs. This bill was passed in the regular session but vetoed by the Governor. Your council feels that ISMS should be in favor of any study which would lead to a solution to this problem. The Board of Trustees has authorized the Council to co-operate in these studies, if and when they may be conducted.

It is requested that the House of Delegates concur in this action.

During the regular session, bills were introduced, with the backing of ISMS, to create a Medical Review Board in the Department of Public Health to rule on the physical qualifications of automobile drivers. These bills failed to pass. However, this legislation has been revived in the adjourned sessions as Senate Bill 1797. The bill provides for a permissive system of reporting physical handicaps to the Secretary of State as a cause for license removal. Physicians who make such reports would be immune from legal action. Except for amendments in wording, which are being sought, this legislation is similar to that which has been previously approved by the House of Delegates and introduced

in several previous sessions of the General Assembly.

The March 4 adjourned session saw 594 new bills introduced, some of which are of interest to medicine. Since the atmosphere in the Legislature is highly political because of the forthcoming elections, it is difficult to predict whether or not any of these will be acted upon. The next adjourned session is scheduled for July 15. It would appear that the stage is being set for annual sessions. Members of the House should be aware that legislation is becoming a full-time year round activity, both in the Congress and the General Assembly. This requires more staff and committee time and it adds to the expense of this phase of the Society's program.

Two resolutions passed by the 1967 House of Delegates were referred to the council. Resolution 67M-17 directs the council to prepare and seek legislation to classify blood and other human tissues as a medical service not as a commodity, subject to control by the Federal Trade Commission. A special sub-committee has been appointed to draft this legislation for introduction in the 76th (1969) General Assembly. Since the way has now been opened up to introduce additional bills in the adjourned sessions of the 75th General Assembly, it may be possible to obtain action sooner.

Resolution 67M-26 directs the council to draft a revision of the Medical Practice Act to prevent chiropractors from taking the examination for any type of license. The practical aspects of implementing this resolution have been discussed with the sponsors of the resolution. It has been pointed out that if the licensing of chiropractors was banned under the Medical Practice Act, they would seek legislation to create their own act. One segment of the chiropractic group has been advocating this for years. We have always opposed this type of legislation because it would allow chiropractors to practice without any control from medicine. The present composite examining committee consists of five M.D.'s, one osteopath, and one chiropractor. The sponsors of this resolution have agreed that a move to ban chiropractic completely is not feasible at this time and that the present composite examining committee is preferable to a separate Board for Chiropractic. Meanwhile, the resolution will remain under study. The new Division of Professional Supervision, established within the Department of Registration and Education, and the new law on advertising, has helped substantially in controlling chiropractic advertising. Under other legislation, chiropractors are now prohibited from performing school health examinations.

Your Council requests that the House of Delegates concur in this method of handling Resolution 67M-26.

During the regular General Assembly Session, your council caused Senate Bill 1396 to be introduced banning the Corporate Practice of Medicine. The bill was aimed primarily at hospitals which employ physicians on salary or contract basis with a subsequent resale of professional services. Medical corporations which, by law, must be composed exclusively of physicians, were excluded. Exclusion was also intended for supervisory services or any services where the collection of a professional fee, by the hospital, is not involved (in accordance with AMA policy on physician control over the collection and disbursement of physicians' fees). The 1967 House of Delegates gave support by the adoption of

Resolution 67M-34. As expected, the Illinois Hospital Association registered strong opposition, including opposition from some members of the medical staffs.

As part of the advance planning on this controversial bill, your council was prepared for either a showdown vote or a strategic withdrawal. The latter course was chosen when, with aid of the bill's chief sponsor, the Hospital Association was committed to meaningful discussions on the question of further intrusion of the hospitals into the practice of medicine. Subsequently an ad hoc committee was formed. One meeting between this committee and representatives of the Hospital Association has been held. Further meetings await the outcome of a survey of salaried hospital practice which the Hospital Association has agreed to and is now conducting.

Your council wishes to re-emphasize the inherent danger of permitting hospitals to gain control of the practice of medicine through the collection of fees of employed doctors. Professional fees properly belong under the control of the physicians who earn them, not under control of the hospital. The objective of this legislation is not the banishment of all salaried physicians in hospitals under all exclusive circumstances. The objective is to prevent the hospital from subjugating the physician to employee status in those areas where private patient care and patient income are involved. Therein lies one of the difficulties of drafting suitable legislation to accomplish this objective. This matter should be of concern to the entire medical staff of the hospital, not simply those involved in hospital-based practice.

Other Committees

Under the new council structure, two committees, Public Affairs and Eye Care, report to the council. The activities of these two committees are described below.

Public Affairs

The Public Affairs Committee has met twice since the 1967 Annual Meeting. A comprehensive program has been developed to involve physicians in governmental and civic affairs. "Educate for '68" has been the theme of the 1967-68 program. The program emphasizes the need for physicians to be cognizant of governmental developments affecting medicine, active in civic affairs, and educated in the processes of government.

The items in the Program are:

- I. Meetings
 - A. One Public Affairs program per year in each County Society
 - B. Regional Meetings (Co-sponsored by larger County Medical Societies and ISMS—Nationally known speakers)
 - C. Public Affairs segment at other ISMS Meetings (Trustee District Meetings, Leadership Conference, etc.)
- II. Monthly Newsletter—*On the Political Scene* and *Educate for '68*
- III. Annual Public Affairs Workshop
- IV. Annual Washington Public Affairs Round-up
- V. Public Affairs Dinner at ISMS Annual Meeting
- VI. Promotion of Statewide Civic Issues on 1968 Ballot
- VII. Advanced Political Education Seminars (optional)

VIII. Awards and Recognition Program

IX. County Society Projects

- A. Operation Courthouse
- B. Candidate Interviewing
- C. Meet the Candidates Night

X. Women's Programs

A number of the county societies have responded to the committee's request to devote a minimum of one meeting a year to a Public Affairs topic. In several instances, your committee has aided in securing suitable speakers and programs. A listing of available films and other program aids is maintained in the headquarters office. We offer our assistance and invite inquiries from program chairmen. The regional meetings bring nationally known speakers into the local areas where the potential audience will justify the cost. The larger county societies act as the host for these meetings with ISMS co-sponsorship aiding in the promotion and cost. Such meetings have been held in DuPage, Lake, and Vermilion Counties. Additional regional meetings are planned. Your committee assisted in providing Public Affairs speakers for the Leadership Conference held in Springfield, April 7th.

A special publication *On the Political Scene* is mailed monthly to over 2500 physicians and their wives. This mailing list includes county society officers, legislative and Public Affairs chairmen, and the key leaders in the societies. In February, a new newsletter, *Educate for '68*, was developed to accompany the OPS newsletter. This special political education insert provides information about the election process. All county societies have been asked to appoint a Public Affairs chairman and a committee to implement programs at the county society level. A special *Public Affairs Chairman's Bulletin* goes to these persons offering suggestions for local activity.

On Nov. 5, over 185 physicians and their wives participated in the one-day annual Public Affairs Workshop held in Chicago. The participants heard from such speakers as U.S. Senator Edward Brooke, Illinois Congressmen Donald Rumsfeld and Melvin Price, plus Washington columnist David Broder. The Annual Public Affairs Roundup was held in Washington, D.C., Jan. 30. Over 75 physicians and their wives attended. The one-day Illinois program included a public affairs program as well as an opportunity for participants to build a working rapport with their congressmen. The highlight of the program was a reception and dinner with members of the Illinois Congressional delegation. The group then attended the U.S. Chamber of Commerce Public Affairs Conference during the following two days. The Committee has again planned a Public Affairs dinner in conjunction with the ISMS Annual Meeting. This dinner features a nationally known speaker, and provides an opportunity for those who attended the annual meeting to hear first-hand reports on national issues.

Other projects in the foregoing listing are being implemented. We anticipate increased interest from the local Societies as the 1968 elections draw near. Physicians wives are invited and encouraged to participate in all of the projects. In addition, we have prepared a special listing of projects to interest the women. These have been published in a manual called *Mr. Lincoln's Wife Awakes—And You!* A special award has been developed for Auxiliary members who devote 24 hours of volunteer time for the candidate of their choice.

Few, if any, physicians would dispute the statement that government has been projected deeply into the practice of medicine. Far too few, however, realize that we stand to lose our leadership if we fail to take an active part in government. It is not enough to simply deal with the executive or legislative branch once it is established. We must take an active part in the political process which creates and sustains the type of government under which we must live. The non-partisan public affairs program is designed to stimulate physicians and their wives to take an active part in the political party of their choice, thereby upgrading the calibre of government, regardless of the party in power. Those who wish to take part in medicine's organized effort to elect specific candidates to legislative office should join and participate in IMPAC.

Eye Care Committee

Under the new council structure, the Eye Care Committee has been reconstituted and made a part of the Council on Legislation and Public Affairs. The committee, under the Chairmanship of Dr. James R. Fitzgerald, has held one meeting in conjunction with the Illinois State Council of Ophthalmology. The State Council of Ophthalmology is a

relatively new organization consisting of representatives of the Chicago Ophthalmological Society and the Central Illinois Eye and Ear Society. It provides a unified voice for the legislative and socio-economic views of ophthalmologists in Chicago and downstate. The committee provides a mechanism for the activities of this specialty group to be integrated into the overall ISMS program.

The Council on Legislation and Public Affairs wishes to express appreciation to the officers and members of the Board of Trustees, members of its own Committees, and members of the many other Committees of the Society which have aided in the Legislative and Public Affairs Program. We wish to thank the staff for the efficient services provided in making the work of the Council effective.

V. P. Siegel, *Chairman*

Paul Richard Allyn	Theodore Grevas
Alfred J. Faber	C. J. Jannings, III
James R. Fitzgerald	Eugene J. Scherba

CONSULTANTS:

J. Ernest Breed	William A. Lees
H. Close Hesseltine	Harold A. Sofield

AUXILIARY:

Mrs. David J. Kweder	Mrs. Alan Taylor
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U.S. Senator

George Murphy

(R. Calif.)

will present

The Camp Memorial Lecture

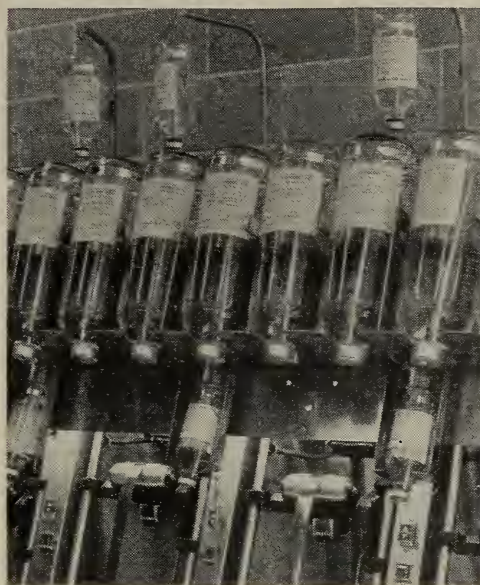
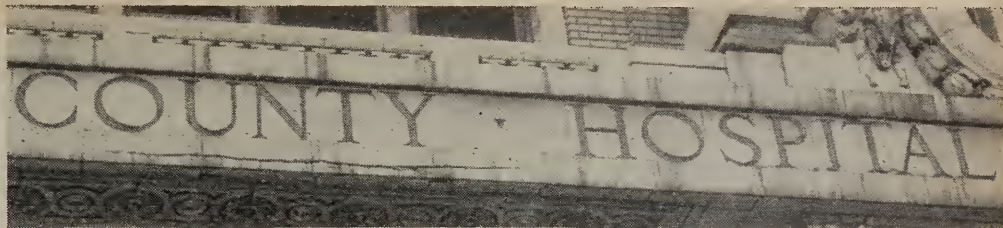
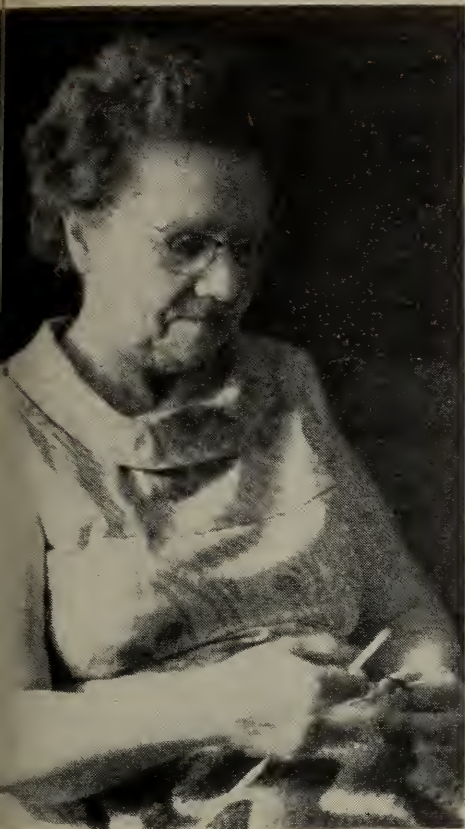
at the

***Annual
Public Affairs
Dinner***

6:30 p.m.
May 20, 1968

Bal Tabarin
Sherman House

\$10.



Council on Medical Service

To assist the Council on Medical Service in future projects, deliberations and meetings, the council established—and received Board of Trustees approval—on the following guidelines.

The Council shall:

- A. Coordinate committee activities, avoid duplication or overlapping of projects, close gaps in medical service programming, and to serve as a catalyst in activating new programs.
- B. Initiate exploration and bring to the attention of the Board of Trustees suggested new policies and philosophies relating to medical service in Illinois.
- C. Serve as an advisory body to allow for the interchange of ideas between various committees of the council.
- D. Consult with council members and chairmen of committees with similar aims and objectives.
- E. Advise the staff of socio-economic issues concerning the patient and to further the health and welfare of the public by seeking continuous improvement of medical services in Illinois.

Recognizing the need to train today's working citizen to better meet the vast physical, psychological and social changes that will confront him when he retires, the Committee on Aging undertook one of its most energetic programs: production of a 13-part, half-hour weekly television series entitled "The Time of Your Life."

The series—co-sponsored through a grant from Blue Shield Plan of Illinois Medical Service—has been taped for initial presentation on WTTW-TV, Channel 11, Chicago, beginning Wednesday, May 1,

It is noted that there seems to be a discrepancy between the Bylaws regarding the duties of the Council on Third Party Medicine (as enumerated on page 428 of the October, 1967, issue, Illinois Medical Journal) and the Table of Organization as outlined on page 450; the Council on Third Party Medicine does not appear to have been activated. In the transmittal from the ISMS office outlining the Table of Organization of the Council on Medical Service and the duties of the committees making up this Council, it appears that the duties of the Council on Third Party Medicine have been delegated to the Committee on Prepayment Plans and Organizations.

Following are the reports of those committees comprising the Council on Medical Services:

The report of the Council on Medical Services is respectfully submitted:

Philip C. Lynch, *Chairman*
 Bertram B. Moss
 Fred A. Tworoger
 Fred Z. White

COMMITTEE ON AGING

1968, and continuing for 13 weeks in the "prime" time slot of 9-9:30 p.m.

Featured on the series is noted broadcast personality Norman Ross, who each week interviews guest authorities on financial and estate planning; how to meet medical expenses; cope with physical and emotional problems; and the constructive use of leisure time.

Fills Information Gap

Through this series, the committee hopes to fill

a large "information gap" that exists in pre-retirement planning not only in Illinois but throughout the nation.

While some larger industries possess the financial resources and facilities to sponsor regular pre-retirement programs for their employees, a vast cross-section of our population working in smaller businesses and industries are deprived of this necessary training. By making tapes of the series available to other TV stations—and films available to smaller businesses and industries—the committee hopes to make pre-retirement training economically feasible for virtually every segment of our population.

National Program

In so doing, it hopes to allay the negative consequences of one of the most serious internal problems our state and nation face—a problem popularly referred to as "the retirement revolution."

Within 30 years, one out of every three persons in this nation will be retired, and live almost a full generation in retirement. Without the preparation to meet his increasingly important role in society, tomorrow's retiree will dissipate the vast economic strength he represents for this nation through unwise budgeting of pensions and savings. In addition, his inability to know how to utilize his spare time will lead to an untimely senility, with its attendant burden upon family, physician and community.

To put the series to work, the Committee on Aging is co-operating with the Blue Shield Plan of Illinois Medical Service in an all-out promotional campaign that will include:

1. Announcement and feature stories in newspapers, TV guides, trade journals, medical society bulletins, and geriatric specialty publications.
2. Descriptive brochures with order forms which will enable television stations or industries to lease, purchase, rent or borrow the films.
3. Station break announcements on both television and radio.

Through these manifold promotional mechanisms this committee hopes to make "The Time of Your Life" series a national prototype for pre-retirement planning, and in so doing help alleviate the unfavorable consequences of the retirement revolution.

A program of such large scope could not have been carried out without the co-operation and diligent efforts of many persons. The committee especially wishes to thank the ISMS Board of Trustees for sanctioning production of this series; the co-operation and tireless efforts of the Blue Shield Plan of Illinois Medical Service, especially Dr. Leo P. A. Sweeney, Dr. H. Close Hesselstine, and Mr. Walter Livingston. We would also like to extend a special note of appreciation to Mr. James Slawny and his staff whose creative and administrative efforts were a vital factor in making this series a success.

Bertram B. Moss, *Chairman*

Edward E. Gordon

Clyde Rulison

John H. Huss

Roger F. Sondag

Alan Olson

Thomas T. Turlentes

CONSULTANTS:

Edward W. Cannady

William K. Ford

AUXILIARY REPRESENTATIVE:

Mrs. Howard A. Lowy

COMMITTEE ON MEDICAL ECONOMICS

During the past year, the Committee on Medical Economics concentrated its efforts on the investigation and implementation of an ISMS-sponsored professional liability (malpractice) insurance program. The program, approved by the Board of Trustees Jan. 21, was introduced to the membership this spring.

In adopting the program, ISMS became only the second state medical society to offer a malpractice insurance policy with built-in safeguards against unwarranted cancellations. The Florida Medical Association has had such a program since 1962.

The ISMS program is underwritten by the Employers Group of Insurance Companies—which also underwrites the Florida program—and will be administered by Parker, Aleshire & Company.

Its major features include:

- Coverage available to all ISMS members, with no restrictions as to age or specialty
- Policies are non-cancellable without just cause
- Claims cannot be settled by the insuring company without the physician's written consent
- The company and ISMS will cooperate in an educational program to show physicians how they can lessen the chances of a malpractice suit being filed against them

In view of these features, the new ISMS insurance program should discourage nuisance suits and help stabilize liability premium rates.

However if the program is to be successful, it must enroll at least 4,000 physicians in the next five years. One of the committee's key activities in the coming year, therefore, will be the successful development of the program.

Tax Qualified Retirement Program

Liberalization of the Keogh Act (HR-10) to permit tax deductions of the full amount invested spurred physician interest in the ISMS Tax Qualified Retirement Program in the past year.

For example, at the end of 1966—under the old Keogh provision—the ISMS program had 89 participants. In mid-January of 1968, with the new provision in effect only a few weeks, participation had increased to 156. The program's administrator, Mr. Paul H. Robinson, Jr., predicts that participation will at least double in 1968.

Through January, total investment in the ISMS Tax Qualified Retirement Program amounted to nearly \$500,000. Of that total, approximately \$450,000 was invested in the Stein Roe and Farnham Mutual Fund and the remainder in the Continental Assurance Company's group annuity.

Retirement Investment Program

This program, endorsed by the Board of Trustees in 1965, is designed to protect physicians against periods of inflation and recession by investing their contributions in a combination of a Continental Assurance Co. group annuity and a no-load Stein Roe and Farnham (Mutual) Stock Fund. It has an added advantage to the physician in that he does not have to include his employees in the program—as he must under the Tax Qualified Retirement program.

Participation in this program has increased by

43 percent in two years—with 121 participants in the first year and 174 at the end of 1967.

Major Medical Expense

The fastest growing of the ISMS insurance programs is the Major Medical Expense plan underwritten by the Commercial Insurance Co. of New Jersey. Prior to its approval by the Board of Trustees in 1965, the plan had enrolled 927 physicians. After the board's endorsement, enrollment increased rapidly to a total of 1,650 at the end of 1967. Total claims paid by the plan in its nine years amounted to \$694,000—and half of that amount was paid in the last two years. Largest claims paid under the program were \$15,000 claims paid to a 51-year-old doctor with carcinoma of the esophagus and to a 42-year-old doctor with chronic renal failure.

Group Disability Program

The oldest of the ISMS-sponsored insurance programs is the Group Disability Insurance plan, also underwritten by Commercial Insurance Co. of New Jersey. First offered in 1946, this plan enrolled only 950 members in its first year and participation increased slowly until the Board of Trustees gave its formal endorsement in 1963. After that action, enrollment jumped to 2,114. Excluding physicians who are ineligible for the program because of age, employment or military service, enrollment now includes 33 percent of the society's eligible members.

A key factor in this program's success has been the balance of participation among the age groups. Since more disability claims originate from the older members, an imbalance of participants over age 50 could make the program actuarially unsound. This is not the case with the ISMS program. Parker, Aleshire & Co., the plan's administrator, reports that there are 61 participants under age 35, 296 participants between the ages of 35 and 39, and 641 enrollees between 40 and 49. The largest group of participants—722—are between 50 and 59, while there are only 71 participants over age 70.

In the 20 years since the program's inception, participants have collected more than \$2 million in benefits—and premium rates have not been increased. Additionally, no premium increase is foreseen in the near future.

Catastrophe Liability Insurance

The Board of Trustees has authorized the committee to explore various plans under which ISMS could offer its members a \$1 million Professional and Comprehensive Personal Catastrophe Liability Insurance Policy. The committee received proposals from four insurance administrators for such a program before deciding that priority should be given to the establishment of the basic professional liability insurance program described earlier in this report.

Fred Z. White, *Chairman*

C. Elliott Bell	Lawrence J. Knox
Bille Hennan	F. Paul LaFata
John J. Holland	Dean G. Peterson
A. Everett Joslyn	Paul Van Pernis
Clifton L. Reeder, <i>Consultant</i>	

Sub-Committee On Relative Value

Because of this committee's experience with standard nomenclature and defining medical and surgical procedures, it has submitted recommendations for

the second edition of the "Current Procedural Terminology" at the request of the American Medical Association. The CPT, a standardized system of procedural terminology, was developed to facilitate the use of standard terms and descriptions for reporting therapeutic and diagnostic procedures.

The Relative Value Study continues to be in demand. The publication, free to members of ISMS, is available upon request.

Requests from non-physicians are considered on an individual basis and, if approved, a charge of \$1 is made. The money is deposited in the society's general fund.

This report is for information only and no action is required by the reference committee.

C. Elliott Bell, *Chairman*

John F. Eggers	R. Gregory Green
Casper Epstein	Gershon K. Greening
Joseph G. Gustafson	

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS

During the past year the Committee on Prepayment Plans and Organizations met several times in order to develop guidelines for review of fee disputes. The guidelines for the operation of the State Committee on Prepayment Plans and Organizations had been approved by the Board of Trustees at the January, 1967, meeting and were reported in the April issue, 1967. During the remainder of the year 1967, guidelines for conducting hearings on fee disputes were developed for use by county and district committees. Although these latter guidelines were approved in principle at the January, 1968, meeting of the Board of Trustees, by official action of the Board of Trustees the committee was asked to study the procedure further and report back to the Board through the Council on Medical Service. The Board of Trustees noted that the 1965 Bylaws contained detailed procedures which might be incorporated as a portion of the committee's duties and responsibilities.

Since the amendments of 1967, the constitutionality and legality of the committee have been ambiguous, and immediate clarification by the Bylaws is mandatory.

The committee returned a decision in one fee dispute during the year, and no cases are pending.

P. C. Lynch, *Chairman*

Preston S. Houk	Max S. Sadove
B. A. Kinsman	E. Lee Strohl
Theodore J. Wachowski	

ADVISORY COMMITTEE TO ILLINOIS DEPARTMENT OF PUBLIC AID

A primary concern of the ISMS Advisory Committee to the Illinois Department of Public Aid (IDPA) during the past year was the breakdown of communications between county medical societies and county public aid departments.

Apparently many county medical societies had not appointed advisory committees to work with the county public aid department; others planned no regular meetings with their county public aid department.

At its March, 1967, meeting, the ISMS Board of

Trustees urged county medical societies to designate such committees to handle matters relating to the medical program of IDPA. A survey conducted in the fall of 1967 showed that 61 county medical societies had complied with this request. The names of these county medical society committees—along with the names and addresses of their chairmen—were forwarded to IDPA.

Administrative Physical Exams

In October, 1967, the committee approved a motion requesting IDPA to pay usual and customary fees to physicians for administrative physical examinations to determine disability. The committee is pleased to note that usual and customary fees for these examinations are now being paid by IDPA.

Direct Billing

The committee held several discussions with IDPA concerning implementation of Resolution 6, which was approved by the ISMS House of Delegates in May, 1967. This resolution deals with the right of a physician to bill the IDPA directly for services provided to a public aid patient who is also a Medicare beneficiary.

IDPA assure us that while it believes changes in the present billing methods are desirable, it does not believe Resolution 6 provides a satisfactory solution. Implementation of the resolution, according to IDPA, would present three problems:

- It is questionable whether IDPA could pay for its recipients when they are covered by Medicare, since IDPA rules require that the recipient take advantage of all other resources before IDPA can assume any responsibility for payment. If the recipient is a Medicare patient, IDPA would consider Medicare to be a primary resource.
- There is doubt whether IDPA would have enough state funds appropriated to make physicians' payments through direct billing prior to the receipt of federal reimbursement to the department.
- Usual and customary fees paid by Medicare's fiscal intermediaries are "considerably higher" than the usual and customary fees paid by the IDPA. It is possible that the IDPA's payment might well be less than the 80 per cent of the bill which would be paid by the carriers.

Policy and Procedure in Renal Failure Cases

The IDPA and the Renal Dialysis Group agreed that the following controls will apply to indigent patients with chronic renal disease:

- A patient with serious chronic renal disease who does not require dialysis as an emergency will be referred to an approved renal unit for evaluation to determine whether he is suitable for chronic renal dialysis.
- The IDPA will authorize payment of hospital costs and professional fees for an evaluation in accordance with established policy and procedure for a maximum of two weeks.
- When extended dialysis is recommended for an indigent patient who is suitable for chronic renal dialysis the director of the Dialysis Unit is to request the IDPA's medical director to approve payment of hospital costs and professional fees. If the patient is found to be eligible for Medical Assistance under Title 19, the Med-

ical Director will authorize payment for extended dialysis.

- When home dialysis equipment and supplies are recommended for a patient with chronic renal disease by an approved renal unit, the IDPA medical director will approve purchase of the home dialysis equipment and supplies as necessary for eligible patients.

Sub-Committee on Cardiovascular Diseases

This sub-committee was originally appointed in 1964 to review individual requests for heart pacemakers and to advise IDPA whether payment should be approved for the pacemakers. The state committee believes there is no further need for this sub-committee and it has been discontinued.

Fred A. Tworoger, *Chairman*

Charles E. Baldree, Jr.	Robert C. Muehrcke
Robert F. Bettasso	Frank B. Norbury
James R. Cooper	Alphonse L. Robinson
Heinz Otto E. Hoffman	William Scanlon
Chauncey C. Maher	Frank P. Skaggs
Rex O. McMorris	John H. Steinkamp
George T. Mitchell	R. Kent Swedlund

Sub-Committee On Drugs And Therapeutics

In fulfilling its responsibility to ISMS members, a new monthly column, "Your Drugs and Therapeutics Committee Reports," first appeared in the *Illinois Medical Journal* in January. The committee will report on a variety of specific and comprehensive subjects, bringing practical knowledge on therapeutics from the medical center to the practicing physician.

The committee continues to refine the list of drugs contained in the Drug Manual prepared at the request of the Illinois Department of Public Aid. In order that the manual will reflect the prescribing habits of Illinois physicians, the committee has spent many hours reviewing physicians' requests for drugs not listed in the manual. A complete and accurate record of physicians' requests and committee actions are kept in the society's office. In developing its recommendations for revision in the manual, the committee is guided by the frequency with which an unlisted drug is requested.

During 1967, the committee reviewed 963 written requests for drugs not listed in the manual and more than 99 per cent were approved. However, a number of requests were returned for additional information such as the patient's name or the medical facts in the case and these are not included in the count.

The committee would like to remind physicians routinely writing for special approval of its serious deliberations in the development of the Drug Manual and ask their cooperation in limiting requests to unusual circumstances.

While the Drug Manual is thought to list the drugs required in the everyday practice of medicine, the committee does not consider it final. Continued experience and constructive criticism by the membership have made it necessary to continually evaluate the listed drugs. The committee's recommendations are reported to the Medical Advisory Committee to the Illinois Department of Public Aid and the Board of Trustees for approval before being submitted to the department for its approval, publication, and distribution to participating physicians.

More than 50 additions were included in the May 1, 1967, revision of the manual. Your committee has again submitted recommendations to the department for a new revision which should be released prior to the annual meeting.

The Illinois Department of Public Aid now requires the physician's medical education number on all prescriptions for its recipients. Each physician's number indicates the state, medical school, year of licensure, and his alphabetical place in class. The committee hopes to use this number to compare the prescribing habits of physicians graduating from different medical schools and year of licensure in a study based on the department's drug usage reports.

The committee appreciates the co-operation it has received from the members as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the Illinois Department of Public Aid for future revisions of the Drug Manual.

This is a report of information and no action is required by the reference committee.

Robert C. Muehrcke, *Chairman*

Joseph D. Cece Edsel K. Hudson
Charles R. Frazer, Jr. Gordon Lucas

CONSULTANTS:

Theodore R. Sherrod Louis Gdalan

ILLINOIS DEPARTMENT OF PUBLIC AID

The legislation passed by the 75th General Assembly in 1967 relating to public aid was all significant to the department; however, Senate Bill 1587, the department's appropriation, was, of course, of major importance. The portion of the appropriation pertinent to the financial requirements for medical assistance for the biennium will be emphasized in this report.

A total of \$763.6 million was appropriated for distributive expenses, and \$329.2 million of this was for medical assistance, 43 percent of the total. Estimated requirements for payments to recipients of Assistance to the Aged, Blind or Disabled and Aid to Dependent Children for basic maintenance items—food, clothing, housing, etc.—totaled \$354.5 million, \$108.4 million for AABD and \$246.1 million for ADC.

Part of the increase can be attributed to a revision of policies and payment procedures to enable Illinois to obtain a maximum of federal funds for every dollar spent for medical purposes. In past biennia, millions of dollars of state money had been channeled through the appropriations of the Departments of Mental Health, Public Health, Children and Family Services, and the University of Illinois, with relatively little federal participation. Now, with the revisions mentioned, the money is channeled through the Department of Public Aid's appropriation which qualifies it for 50 percent in federal matching funds.

Therefore, the appropriation includes money for payments for medical care for persons—needy by Public Aid's definition—formerly not eligible for assistance from the department but eligible for programs of other state agencies. The estimated requirements—identified with the administering agency—for the additional expenditures at the time the appropriation was prepared were: \$82 million for needy persons age 65 and over in state mental institutions

(Department of Mental Health); \$3.46 million to pay the costs of needy persons who receive care at the Illinois Eye and Ear Infirmary (Department of Children and Family Services); \$3.4 million for providers of goods and services for children in foster care settings under the supervision of the Department of Children and Family Services, or the Cook County Department of Public Aid; \$3 million for needy patients who receive care at the Illinois Research Hospital (University of Illinois); \$2.4 million for needy persons age 65 and over in state tuberculosis hospitals (Department of Public Health); \$14 million for needy persons 65 and over in county and municipal tuberculosis sanatoria; and \$800,000 for providers of goods and services for needy persons eligible for the Division of Crippled Children program (University of Illinois).

Since September, 1966, federal funds have been available to meet 50 percent of the cost of the care of needy aged patients in state mental hospitals, and for the others mentioned here, since July 1, 1967. With reference to the care of needy aged persons in county and municipal tuberculosis sanatoria, state money will pay part of the cost of their care which is now paid from local levies, and federal funds will make up the balance. Public Aid payments to providers of goods and services for needy persons eligible for the Division of Crippled Children program will increase the percentage of federal participation, with a proportionate decrease in the percentage of state funds required.

Physicians' Fees

The \$109.5 million in state and federal money to pay for medical care for persons not previously eligible under Public Aid's regulations is only a part of the estimated increase in medical costs. An increase in both the cost of services and their utilization by persons on the rolls was projected. Also, some movement into preventive services was considered.

For example, since Jan. 1, 1967, fees for physicians' services have been based on their usual and customary charges, in accordance with an agreement between the department and the Illinois State Medical Society. Prior to that time, payments had been based on the fees established by the department with the advice and assistance of the Illinois State Medical Society. The increase in this item will raise the cost of physicians' services substantially during the 1967-69 biennium. Payments for physicians' services by month of payment were \$5,763,000 in calendar year 1966 and increased to \$9,988,000 in calendar year 1967. Bills paid under the new payment in 1967—excluding those in which Medicare was involved—were paid at better than 94 percent of charges.

Techniques for handling bills for payment have improved substantially, and at this point, the backlog of bills has virtually disappeared. Upwards of one-half million medical bills for all types of medical care are processed during a month, and such a volume inevitably produces problems, resulting in occasional delays. However, there is an on-going review of procedures, and a constant effort is being made to improve every aspect of the payment procedure.

The cost of hospital and nursing home care, dental and eye care, drugs, and other medical services has increased, and all add proportionately to the estimated \$329 million requirement for medical assistance in the current biennium.

Cost of Hospital Care

The increase in the cost of patient care in general hospitals is a matter of concern, because it has exceeded the rate of increase anticipated by the department when the appropriation needs were estimated. At that time, general hospital costs were expected to be \$56.8 million for the biennium; the current estimate is \$90.8 million.

For the 75th biennium, the department planned improvements in payments to group care facilities. These were considered necessary in view of the impact of the involvement with Medicare, adjustments in the cost-of-living index, changes in the minimum wage, and the shortage of facilities in most of Illinois. Rates were increased in May and September, but these were interim increases pending the development of a comprehensive classification system for all facilities and patients which could be adopted by all state agencies engaged in licensing or purchasing care from the facilities. After the system of classification was completed, it was tested in a survey of over 14,000 recipients living in group care facilities in January, 1968. Effective in February, 1968, the plan for classifying patients in relation to the amount and kind of care required will be adopted. Consideration has been given to fund limitations in the biennium, but it appears that there will be a four percent improvement in payments for nursing home care, with a minimum potential for some reductions in payments compared to January, 1968, levels.

Dental Program

The Department of Public Aid and the State Dental Advisory Committee have devised a plan which has the basic feature of establishing a statewide maximum allowance for the various procedures in the field of dentistry. The dental program will continue to include only those services necessary to prevent dental disease and to restore and maintain adequate dental function to assure good health. Services to improve appearance will be limited to situations where employment is a factor.

The present fee schedule the department is using, for the most part, has been in effect since July, 1957, with some minor upward adjustments in February, 1964, for fillings, dentures, and simple extractions. Currently, the department is paying approximately \$3 million per year for the dental services program, and an anticipated need for an increase was included in the biennial appropriation.

On the basis of the department's review of pertinent information and the recommendations of the State Dental Advisory Committee, usual and customary fees are to be billed by participating dentists. The fees will be paid if they are within the maximums established by the department.

The revision in payments for dental care, which will be effective April 1, 1968, may increase expenditures in the dental program approximately 50 to 60 percent for the biennium.

Payments for Eye Care

Payments for eye care will be made for services provided by optometrists, as well as ophthalmologists. Payments for refraction procedures, dispensing fees, glasses and frames will be based on usual and customary fees, up to maximums established by a survey of practitioners providing like services. Serv-

ices to ophthalmologists involving diagnosis and detection of eye diseases will be paid in accordance with the department's established policy for physicians' services.

The enactment of Illinois House Bill 1338 provides for podiatrists' services to public assistance recipients without prior approval of a licensed physician. The bill was effective Jan. 1, 1968. This differs from department policy in the past which required that a physician had to indicate the need for podiatry services and arrange for referral to a licensed podiatrist.

In preparation for the implementation of House Bill 1388, a State Advisory Committee on Podiatry was appointed upon the recommendation of the Department staff and the Illinois Podiatry Society. The committee, composed of members and non-members of the state society, is to advise the department on suggested fees, areas of service to be covered, utilization controls, and any alleged abuses of this program.

The department has met with the committee and, in conjunction with the State Podiatry Society, has surveyed podiatrists throughout the state for information on usual and customary fees in effect Nov. 1, 1967. The program will be on a limited basis, excluding routine foot care. Under the previous program, when a physician's referral was required, expenditures for podiatry approximated \$30,000 per year. The department will keep this program under close observation to determine the financial implications of recipients having direct access to podiatry services.

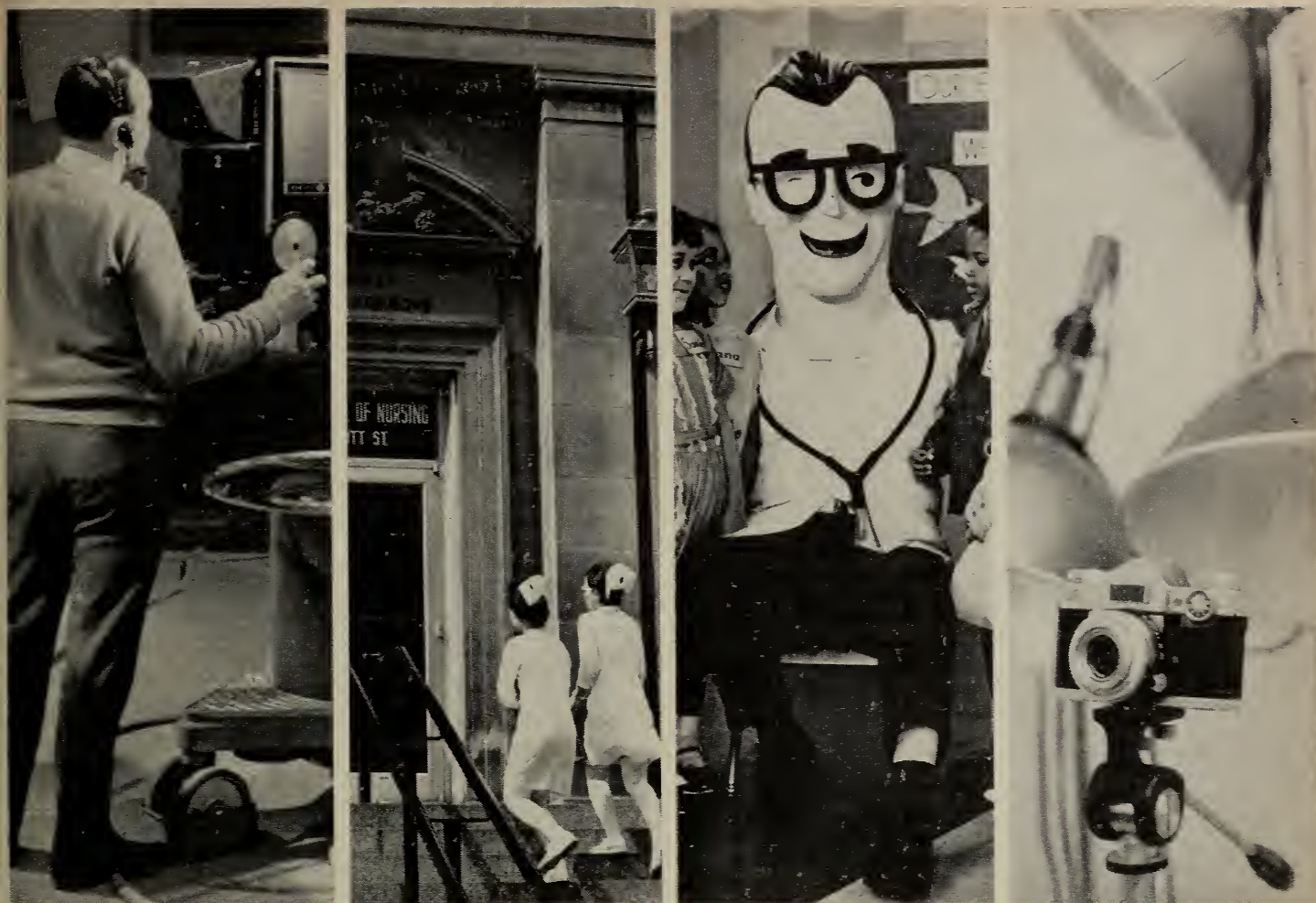
Immunizations for Children

The Illinois School Code requires that children have physical and dental examinations and immunizations against various diseases immediately prior to or upon their entrance into kindergarten or first grade, and upon entrance into the fifth and ninth grades, or upon first entering school in Illinois, regardless of the grade. When there is an organized plan for examining and immunizing children, and *all* children are required to pay, the department will pay for the established charge for eligible children receiving ADC or eligible for medical assistance only. If there is no organized community program for providing the services, and each family must make plans for having their children examined or immunized, the department may then pay for the services for children eligible under the ADC or medical assistance only programs.

The material herein relates closely to past and current developments in the department's medical care program. A great deal of credit must go to the professional help we have had from representatives in the various fields of medical care.

A recurring deficiency in the whole area of medical care—and it does not pertain only to care for persons eligible for public aid—is the inequitable distribution of physicians and medical facilities. The matter is called to the attention of the department frequently, because the problem does exist to a great extent in the poorer areas where many recipients live, not only in the city ghettos but in some of the rural areas. The department's involvement with medical care is limited to payment for services given, and while the problem of availability of services is of concern to us, its solution should be generated by others. It seems appropriate to end this piece by calling this to the attention of the readers.

Harold O. Swank, *Director*



Council on Public Relations

The Council on Public Relations met in the summer of 1967 to plan and coordinate committee projects for the fall and winter. Following are the committee reports on these projects.

Max Klinghoffer, *Chairman*

Julian W. Buser

Matthew B. Eisele

Henry A. Holle

James D. Majarakis

Robert S. Mendelsohn

W. I. Taylor

Leo P. A. Sweeney, *Consultant*

ADVISORY COMMITTEE TO OTHER PROFESSIONAL GROUPS

During the past year, the Advisory Committee to Other Professional Groups concerned itself primarily with the work of the Illinois Interprofessional Council of the Health Professions and the Illinois Association of the Professions. Following is a report on our liaison with these organizations:

Interprofessional Council

ISMS is represented on the Illinois Interprofessional Council of the Health Professions by Dr. Walter Reedy, Dr. Andrew Brislen and Dr. James D. Majarakis, who serves the council as second vice president.

The council consists of representatives from the Illinois Dental Society, Illinois State Veterinary Medical Association, Illinois Podiatry Society, Illinois Optometric Association, Illinois Pharmaceutical As-

sociation and ISMS, whose combined membership of these organizations totals 50,000 members.

Purpose of the council's monthly dinner meetings—at which we have been fully represented—is to discuss subjects of mutual importance to all professions. Resolutions approved by the council, e.g., air and water pollution, are forwarded to the public relations division of each member organization for their support.

Preparations are underway to obtain a U. S. Public Health Service grant for a study to determine what happens to the students of the six organizations represented in the council, who drop out of school during training.

It is the unanimous opinion of the Advisory Committee to Other Professional Groups that ISMS representation in the council serves as a constructive,

congenial and useful purpose for it gives us an opportunity to exchange views on mutual problems.

Illinois Association of the Professions

The Illinois Association of the Professions is a nonprofit corporation, incorporated under the laws of Illinois on Feb. 6, 1964. Several other states such as Michigan, New York and North Carolina have already organized associations of professions with the same basic structure and purpose. Other state organizations are in the process of formation. An American Association of the Professions has been incorporated, and the first major meeting of a representative group of professional men was held in Harbor Springs, Michigan, in July, 1967, for the purpose of "looking towards the development and implementation of the AAP."

The IAP as a corporate body continues to meet approximately every three months and conducted its fourth annual meeting on Oct. 20, 1967. Some significant progress in the organization can be reported, especially in the area of co-operative legislative planning. Legislation in the name of HB 2432 was enacted in the 75th General Assembly and approved by Gov. Otto Kerner. This legislation creates a "Division of Professional Supervision" in the Department of Registration and Education. The executive committee has reviewed the committee structure of the IAP, and has reduced the original sixteen committees to nine, by combining the groups through their related activities. A vigorous membership campaign is being initiated, and it is hoped that additional members of the medical profession, as well as other professionals, will join the organization at the modest dues of \$10 per year. Dr. George F. Lull is the new Executive Director of the Illinois Association of the Professions.

ISMS representatives on the IAP Board of Directors are Drs. George B. Callahan, Edward A. Piszczek and Eugene L. Vickery.

James D. Majarakis, *Chairman*

Lawrence J. Bowness

Raymond Schale

Walter J. Reedy

Eugene L. Vickery

Vincent C. Sarley

David Whitsell

CONSULTANTS:

Andrew J. Brislen

George Callahan

E. A. Piszczek

ADVISORY COMMITTEE TO PARAMEDICAL GROUPS

During the past year, the Advisory Committee to Paramedical Groups reviewed guidelines for out-of-hospital physical therapy services at the request of Dr. Franklin Yoder, Director of the Illinois Department of Public Health.

The guidelines—prepared by and intended for use by the Illinois Chapter of the American Physical Therapy Association — were given careful scrutiny and returned to Dr. Yoder with suggested revisions. The committee also recommended that Dr. Yoder urge the chapter to work closely with ISMS representatives in the implementation of its out-of-hospital services.

The remainder of the committee's work was concerned with the coordination of its subcommittee's activities.

W. I. Taylor, *Chairman*

A. L. Burdick

Thomas R. Harwood

Edward J. Krol

Advisory Committee To The Health Careers Council Of Illinois

The Advisory Committee to the Health Careers Council of Illinois is charged with the responsibility of advising HCCI on careers in medicine; assisting it in developing new financial resources; and keeping ISMS membership abreast of the need for health personnel.

A non-profit organization comprised of 23 health career groups—including ISMS—HCCI was established to serve as an authoritative information center on health occupations and as an effective mechanism for the conduct of career guidance programs.

In support of its efforts, the 1967 ISMS House of Delegates allocated to HCCI \$2 of the \$20 our members had contributed to AMA-ERF through the existing dues structure. After careful review of HCCI's accomplishments, the committee recommends continued financial support of HCCI at the same level as last.

Unless another source is available from which to obtain these funds, the committee recommends that the HCCI contribution again be allocated from the AMA-ERF fund. It further recommends a three-year pledge of this support, with a review at the end of the second year.

With the growth of new technologies and ever-increasing demands for health services, the number of para-medical professional, sub-professional and auxiliary personnel continues to grow at a faster rate than the number of physicians.

In 1950 there were approximately eight other health workers for every physician. Today there are about fourteen, and by mid-1970—when this ratio will increase to somewhere near 20 to 1—health will be the largest single employer of manpower in the United States.

The critical challenges involved in recruiting, educating and making good use of such health manpower prompted ISMS leadership in forming the Health Careers Council of Illinois. As a result of the 1967 action of the House of Delegates, ISMS is one of the two principal supporters of the council. ISMS and its Auxiliary have been influential in developing several aspects of HCCI's program, which now consists of a three-pronged attack on the problem embracing (1) career recruitment and public information, (2) educational development and (3) related planning and research.

Career Recruitment—Primary concentration in recruitment is on the 40 to 50 "entry-level" careers needed in every community in Illinois. Without the skills represented, it is almost impossible to induce physicians to locate in an area, and at present there are about 20,000 budgeted vacancies for professional and technical personnel in hospitals throughout the state.

HCCI methods include: school career conferences, programs, clubs and seminars; volunteer and paid work experience; publications for youth and for adult leaders; publicity, and guidance counselor and teacher education. Many programs pioneered in Illinois are now being adopted elsewhere.

Educational Development—In encouraging development of health occupations curricula within the state, HCCI serves as a meeting place and a source of information for health professionals, health facilities, educators and the general public, the four ele-

ments needed in the successful development of health occupations programs. In providing education close to home, our expanding junior college system offers real hope, and HCCI worked with many of these in the last year in encouraging new programs which meet real needs.

Related Planning—As one concrete example of the need for efforts in recruitment and retention of paramedical personnel. Illinois is fourth in population and third in the production of nurses among the 50 states. California is first in population and only eighth in the production of nurses, yet California has more nurses per 100,000 people than we do. And, with all of California's obvious attractions, the California State Medical Society is putting \$50,000 a year into the California Health Manpower Council, Health Careers counterpart in that state.

The health careers advisory committee, and the board and staff of the council, do not believe that matching this sum is necessary because of a number of differences of approach in our program in Illinois—but they do believe that the present contribution is the rock-bottom minimum necessary to carry out effective programming in recruitment, educational development and any related research and planning.

At its November annual meeting, the Illinois Hospital Association re-affirmed its contribution toward the annual support of HCCI in the amount of \$79,000 per year. This sum, together with ISMS' \$2 per doctor contribution, represents the basic operating fund for insuring that the necessary fundamental program will continue uninterrupted over the period of years necessary to produce meaningful results. (For example, it is necessary to direct eighth and ninth graders toward health professions because many of them are making decisions concerning their high school programs which will qualify or not qualify them for entry into most career schools.)

Other funds accruing to the council because of this basic support are increasing year by year, last year reaching nearly \$30,000 in contributions from foundations and other private sources. In the coming year the council's goals are for \$29,500 in new funds, and prospects for receiving this are excellent at present, including a substantial federal grant for a project investigating more than 400 health technology programs below the MD level now in existence in the state.

It is your committee's opinion, however, that the chances of HCCI's achieving such support would be considerably diminished without continued strong evidence of approval by those to whom both professionals and the general public look to for leadership in matters medical.

Allison L. Burdick, Jr., *Chairman*

John B. Hall, Jr. J. E. Purdy
Samuel B. Nelson Joseph C. Sodaro

CONSULTANTS:

James B. Hartney Maynard I. Shapiro
William McCarthy

Advisory Committee To Illinois Medical Assistants Association

The ISMS Advisory Committee to the Illinois Medical Assistants Association reports continued cooperation with the IMAA.

The ISMS staff and advisory committee have rendered counseling, professional assistance and part

time secretarial help for the following IMAA activities:

- (1) Editing, publishing and distributing the monthly "Executive Memo" with the co-operation of Mrs. Synobia Payne, President.
- (2) The preparation of news releases regarding the annual convention, educational symposiums and Training Seminars.
- (3) Printing the officers' and committee chairman's annual reports, council meeting minutes, and special promotional pieces.
- (4) Assisting in the publication of the IMAA Quarterly Newsletter.
- (5) Assistance in procuring speakers for conventions and symposiums.

As in the past, IMAA has reimbursed the society for a portion of such out-of-pocket expenditures as secretarial services, paper, printing and plates used in IMAA projects. Services provided by the society's staff are available without charge. The Public Relations Director serves as staff co-ordinator for all IMAA projects channeled through the society.

During the past year the chairman and various committee members attended the council meetings, educational meetings and an organizational meeting and offered assistance when requested.

The major problem of IMAA at the present time is recruiting new members. Because of this problem, the committee chairman wrote all county society presidents in an attempt to stimulate their interest and help in recruitment.

The IMAA Advisory Committee believes the programs which have been started are helping to promote a worthwhile relationship between the organizations, and their future implementation will sustain and enhance the relationship.

Thomas R. Harwood, *Chairman*

Carl Birk Clarence G. Glenn
Donald E. Dick H. H. Pillinger, Jr.
George Dohrman Maynard I. Shapiro
Earl W. Donelan Paul G. Theobald

CONSULTANTS:

Carl E. Clark Caesar Portes
Philip G. Thomsen

Sub-Committee On Nursing

The nursing committee had two formal meetings up to the time of writing this report. Representatives of the Illinois League of Nursing and the Illinois Nurses Association were present at the first meeting. The following items were considered and acted thereupon as recorded.

I. A reiteration of the need for a formal listing of dependent and independent functions of the nursing staff by each hospital in Illinois. This had been recommended in the past and approved.

II. The committee was pleased that the board chose to recognize the need for an independent observer—a member of the Illinois State Medical Society—to be on hand in disputes between nursing staffs and hospitals. The committee feels that the observer should be either the trustee in whose district the controversy occurs, or a member of the nursing committee if geographically more convenient.

III. The committee recommended for the board's consideration a joint meeting of nurses and physicians for the state of Illinois. This meeting would be a result of, and patterned after, the national AMA-ANA meetings held for the past several

years. The details of this meeting, should it be approved, would be the responsibility of the Board of Trustees, with whatever help is necessary from the Nursing Committee.

IV. The Nursing Committee noted the absence of the participation of the Illinois State Medical Society in the Illinois Study Commission on Nursing. Request for funds to assist in this study had been denied in the past.

The study is nearing completion, but still no representative of the medical profession representing Illinois State Medical Society is listed on the commission or its committees. The Nursing Committee feels that support of this survey has definite merit.

V. Much discussion occurred during committee meetings concerning the need for more nurses. This apparent shortage is felt by some committee members to be due to changes in nursing education.

Ted LeBoy, *Chairman*

T. J. Conley,	H. J. Kolb
Angelo P. Creticos	Clarence Norberg
Henrietta Herbolzheimer	Nicholas P. Primiano

CONSULTANTS:

Willard C. Scrivner	W. I. Taylor
Mrs. Mitchell Spellberg,	<i>Auxiliary Representative</i>

Advisory Committee To Student American Medical Association

During the past year, the committee met with the five Chicago chapters of the Student American Medical Association to acquaint them with the principles of organized medicine and to offer ISMS assistance with their chapter projects.

At the meeting, SAMA representatives requested ISMS assistance in establishing a program for medical students to work as summer assistants in physicians' offices between their freshman and sophomore years. They also asked to be invited to attend ISMS scientific meetings and for assistance in the publication of chapter newsletters and bulletins.

The committee also:

- Agreed to provide \$200 to each of the five chapters to help send a representative to the National SAMA convention in Detroit in May.
- Invited chapter presidents or their representatives to attend ISMS Board of Trustees meetings to familiarize them with the workings of the state society.

The committee co-operated with the five Chicago SAMA chapters in providing invitations, posters and campus maps to publicize a panel discussion on "Sex and Medicine Today" at the University of Illinois Medical Center.

Edward J. Krol, *Chairman*

Hilger P. Jenkins	Edward S. Petersen
Max M. Montgomery	David B. Radner

COMMITTEE ON DISASTER MEDICAL CARE

The major emphasis of the Committee on Disaster Medical Care during the past year centered on four important areas—Packaged Disaster Hospitals (PDH); ambulance service problems; the Medical

Self-Help program; and the problems of disaster care relative to civil disorders and intermediate disasters.

Packaged Disaster Hospitals: Continuing to lead the nation in the PDH training program pioneered in Illinois, the committee assisted in four training sessions during the year.

The training sessions were sponsored by ISMS, the Illinois Civil Defense Agency, the regional office of the U. S. Public Health Service, the Illinois Department of Public Health and Memorial Hospital of DuPage County. The committee plans to undertake about four training sessions a year for an indefinite period.

The committee's goal of establishing three PDH training centers in the state is now coming closer to realization. In addition to training sessions at the already established centers in Springfield and at Elmhurst, one pilot session was held in Carbondale and at least two other cities have indicated definite interest in the location of PDH training facilities.

Civil Disorders and Intermediate Disasters: The committee outlined its feeling in communications with Illinois Hospital Association and various other concerned agencies that—in the event of civil disorders—"hospitals must represent a type of sanctuary and that all medical personnel must be free to treat patients without fear of injury to themselves or damage to the facilities in which they work."

The committee also urged creation of adequate communication systems in disaster situations.

Two members of the Disaster Medical Care Committee attended December and March meetings with representatives of other health oriented groups, city, county, state and federal government officials to discuss the development of an "Emergency Health Preparedness Plan" for Metropolitan Chicago. Purpose of the plan is to assure prompt and coordinated medical care in an intermediate disaster situation. Our committee representatives serve in an advisory capacity to the other agencies involved.

A Special Sub-Committee on Ambulance Services was appointed by the Board of Trustees to serve on a newly-organized Ad Hoc Commission on Ambulance Services.

The ISMS delegation to the commission consists of: Max Klinghoffer, M.D., Harold Lueth, M.D., Colman O'Neill, M.D., James Kurtz, M.D., and William Hark, M.D.

Three subcommittee members attended the organizational meeting of the commission earlier this month. The commission—called into being at the request of the Illinois Funeral Directors Association—was organized to maintain and improve standards of ambulance service in Illinois.

It will also serve in an advisory capacity to help bring ambulance service to those communities in outlying districts not now having such service. The commission will also assist in legislative efforts when necessary and cooperate with all governmental bodies in studying the needs and apparent problems of more effective treatment and transportation of casualties to medical facilities.

New Members: Two members were added to the committee by Board of Trustees Chairman Dr. Goodyear. They were William A. Hark, M.D., Chicago, and Charles F. Sutton, M.D., M.P.H., Springfield.

The chairman of the Committee on Disaster Medical Care commends all committee members who have participated with enthusiasm through the year.

Max Klinghoffer, *Chairman*
 Jack R. Baldwin Harold C. Lueth
 William A. Hark Carl Steinhoff
 Edwin A. Lee Charles F. Sutton
 CONSULTANT:
 James Hartney

Sub-Committee On Public Safety

The Committee on Public Safety during 1967-1968 directed its activities to the areas of safety legislation, public information and safety study.

Legislation

The committee re-affirmed support for Senate Bill No. 8 (Implied Consent); suggested amendments to the ISMS Council on Legislation concerning SB No. 1797 (Medical Review Board); and reviewed Illinois Department of Public Health plans to qualify persons administering blood alcohol tests under SB No. 7 (lowering blood alcohol level).

Public Information

The committee also assisted in developing the medical message for a manual called "Rules of the Road," which received statewide distribution by the Secretary of State's office.

It also continued its program of co-operation with the Accident Crash Injury Research of Cornell University by soliciting participation of ISMS members in follow-up investigation.

Interest and support of the Illinois Eye Injury Study by the committee continued during the year. The Illinois Hospital Association agreed to assist in distributing follow-up forms to Chicago area hospitals. Results of the study to determine the frequency and extent of eye injuries are expected in the near future.

Three committee members represented ISMS at a regional meeting of the American Medical Association's Committee on Medical Aspects of Automotive Safety at Louisville, Kentucky, Jan. 28, 1968. Motorcycle safety was the main item of discussion.

Air Safety Study

The committee held a special meeting, Feb. 8, 1968, with several guest experts to evaluate information concerning pilot drinking and aircraft safety. The committee's preliminary conclusion was that the problem of pilot drinking is not as serious as implied in some published reports.

Edwin A. Lee, *Chairman*
 James P. Campbell Norman J. Rose
 Julius M. Kowalski Clifford P. Sullivan
 Mrs. Don Morehead, *Auxiliary Representative*

COMMITTEE ON HOSPITAL RELATIONS

The major project of the Committee on Hospital Relations during the past year was the development of a series of programs on utilization review problems in co-sponsorship with the Illinois Hospital Association.

The programs—designed to help UR committees function more efficiently and effectively—will be directed to UR chairmen, hospital chiefs of staff,

executive committees, administrators and medical record librarians. The half-day programs, to be launched this spring, are planned for five to 10 different cities throughout the state.

Cost of the project will be shared by ISMS and IHA.

Since the problem surrounding Senate Bill 1396 (Corporate Practice of Medicine) is within the committee's province, the committee endorsed Part C of the AMA's Council on Medical Services report on which SB 1396 is based. It also sought, and obtained, representation at all meetings of the the ad hoc committee to meet with the Illinois Hospital Association to resolve the problem.

In addition, the Board of Trustees approved two policy recommendations of the committee. They are:

(1) "Utilization Review Committees of hospitals and nursing homes are urged not to release findings to any third parties, including governmental agencies. Any reports issued by the committee should be submitted to the chief of staff for his disposition."

(2) "Audits and surveys which impinge on personal privacy, quality of patient care, and local trustee and medical staff decisions as to hospital management should be scrupulously avoided."

J. W. Buser, *Chairman*
 John A. Bowman Donald A. Meier
 Harlan English Kenneth J. Smith
 Noel G. Shaw, *Consultant*

MEMBERSHIP COMMITTEE

The Membership Committee held one meeting during the year but did not authorize any projects because it lacked a quorum. Before a second meeting could be called, Chairman Dr. Joseph F. O'Malley passed away. On Jan. 23 the Board of Trustees appointed Dr. Henry Holle to succeed him as chairman and added Dr. H. Close Hesseltine as consultant to the committee.

Henry Holle, *Chairman*
 Roger Hoekstra Fritz Koenig
 Burton J. Soboroff
 H. Close Hesseltine, *CONSULTANT*
 Mrs. Alden Rarick, *AUXILIARY REPRESENTATIVE*

COMMITTEE ON PUBLIC RELATIONS

The past year saw a dramatic change of emphasis in the committee's programming—from health education to membership relations.

While the committee continued such popular health education features as the Dr. SIMS newspaper column, the monthly teen column, daily radio spots and state fair exhibit, it concentrated its efforts on internal relations with the ISMS membership.

The two biggest programs in this area were: (1) The President's Tour; and (2) ISMS Government Health Programs Workshop.

President's Tour

The President's Tour, launched last fall, is a program designed to showcase our president and president-elect on a cross-state goodwill tour of county medical societies, service organizations, radio, TV and newspapers.

Its purpose? To personally communicate with grass roots members, county society officers, community

leaders and the media. It was also designed to give our leaders a platform to speak out on issues of vital concern to the profession.

The President's Tour took Drs. Newton DuPuy and Philip Thomsen to 12 different cities including Rock Island, Moline, Danville, Chicago, DeKalb, Champaign, Springfield, Bloomington, Waukegan, Decatur, Alton and East St. Louis.

They discussed Usual and Customary Fee Problems, Corporate Practice of Medicine, Medicare-Medicaid to county societies, while service organizations heard about The Physician Shortage, Quackery and Advances in Medicine.

They addressed more than 1,000 ISMS members, 800 community leaders and appeared on 12 radio programs and nine television programs and had more than 100 news stories published in the Illinois press.

In view of the success of the program, the committee plans to resume the President's Tour next fall.

Health Program Workshop

Another new program directed to the membership was our highly successful Workshop on Government Health Programs held February 15 in Belleville.

The program was designed to help physicians and medical assistants learn the intricacies of government health programs, determine eligibility, complete forms and be assured of prompt, correct payment.

The workshop—co-sponsored by the St. Clair County Medical Society and the St. Clair County Medical Assistants Association—drew almost 200 people. Due to its overwhelming popularity and importance to the membership, similar workshops are planned throughout the state following the annual meeting.

Journalism Fellowship

The committee scored a public relations breakthrough with the establishment of the nation's first Medical Journalism Fellowship program for newspaper reporters.

Purpose of the program is to improve the quality of medical writing and increase coverage of medical society news by non-metropolitan newspapers.

Recipients of the first fellowships were Charlotte Huser, Decatur Herald-Review, and Robert Westerbeck, Rockford Register-Republic, who participated in an intensive-four-day workshop at the ISMS' 1967 annual meeting.

Throughout the program, Miss Huser and Mr. Westerbeck followed an agenda planned by the committee to provide intensive exposure to every phase of convention activity. The reporters attended reference committee hearings, scientific programs and the House of Delegates sessions, as well as working in the press room.

The success of the 1967 Fellowship Program has encouraged the committee to make the Fellowship a permanent part of the ISMS PR program.

Radio and Television

Again ISMS compiled over 550 hours of public service broadcast time—or 24 full days of airtime during the year.

In establishing this record we placed over 100 different physicians on almost every interview program in the Chicago area, as well as in Springfield, Decatur, Rock Island, Moline, Champaign, Danville

and Alton. The bulk of our broadcast time, however, was compiled throughout the state on programs produced and distributed by ISMS itself. They include:

- *Dr. SIMS Radio Health Tips*—These daily, 30-second practical health tips are being aired by 56 stations throughout the state. During the past year, they were broadcast over 30,000 times including 552 times by Station WLS, Chicago.

- *One-Minute TV Spot*—Our lone TV public service spot, on the subject of German measles, was telecast over 100 times by stations throughout Illinois.

- *Medical Interview*—This weekly five-minute discussion was aired regularly on 42 different radio stations throughout the state.

Community Health Week

In recognition of the need for better sex education programs in schools and homes, the Subcommittee on Community Health Week chose "Sex Education and Family Life Training" as its CHW theme for 1967.

To call attention to the Oct. 15-21 promotion, Chairman Dr. Matthew Eisele named syndicated columnist Ann Landers as honorary CHW chairman. Miss Landers lent her name and talents to the preparation of a 12-page ISMS publication called "Sex Education and Family Life Guide," which was promoted through news releases and radio spots featuring Miss Landers.

The result? Requests for over 5,000 guides including 3,500 from the State Superintendent of Public Instruction who placed them in every public school in Illinois. In addition, more than 100 radio stations broadcast the CHW promotional spots the week prior and during CHW.

Sex Education Records

Dr. Lee Winkler's Subcommittee on Special Events reported the sale of approximately 500 albums of the Dr. SIMS phonograph record "When Your Child Asks About Sex." This included the purchase of some 200 albums by the Chicago Board of Education for use in schools throughout the city.

Sale of the record—which features the voices of Dr. SIMS (Dr. Max Klinghoffer) and CBS radio personality Mal Bellairs—brought over \$1,700 to the ISMS Educational and Scientific Foundation through which it was produced and distributed.

Medical Journalism Awards

To acknowledge outstanding achievements in medical journalism—and stimulate improved radio-TV-newspaper coverage of medical events—the committee conducted its fourth annual Medical Journalism Awards program.

The program, which has received wide acclaim, attracted over 160 entries, which were judged by a panel of experts provided by the Publicity Club of Chicago. Assisting them were Drs. Matthew B. Eisele, Lee Winkler, Charles Vil, and Catherine Dobson.

Honored at a special March 23 Awards Dinner were: Television Stations WTTW, Chicago; WMAQ, Chicago; WHBF, Peoria; WICS, Springfield; WBBM, Chicago; Radio Stations WLS, Chicago; WIND, Chicago; WGN, Chicago; WKRS, Waukegan; WMBD, Peoria; Newspapers: Waukegan News-Sun; Rockford Morning Star; Moline Daily Dispatch; Rockford Register-Republic; Chicago Sun-Times; Chicago

Tribune; Chicago Daily News; Lerner Home Newspapers; Lake Forester; The DuPage Press; Park Ridge Advocate; Champaign News-Gazette and freelance writer Ted Berland.

Newspaper Features

One of the most important aspects of our health education program is the work done by Dr. Charles J. Weigel's Subcommittee on Newspapers.

Its weekly Dr. SIMS health column grew so popular that the committee re-issued it in February as a daily feature entitled "Dr. SIMS Says." The new feature is being supplied to a select group of newspapers in mat and reproduction proof forms.

Meanwhile, "Dr. SIMS Talks to Teens" continues to be published in over 300 high school publications on a monthly basis.

State Fair

For the fourth consecutive year, Dr. SIMS maintained an "office" at the ISMS exhibit during the 1967 State Fair in Springfield. Dr. SIMS—portrayed by a representative of the PR staff wearing a three-foot high plasticized head—participated in the opening day parade and again attracted record-breaking crowds to the ISMS exhibit.

Parents and children alike shook hands with the ISMS symbolic emissary in what amounted to the most successful state fair promotion in ISMS history. Dr. SIMS proved an ideal good-will ambassador as he distributed to youngsters some 10,000 balloons bearing the image and health message of Dr. SIMS of the Illinois State Medical Society. In addition, volunteers from the Sangamon County Woman's Auxiliary distributed over 6,000 packets of health information materials to adults.

Fifty Year Club

Some 138 members and guests of the Fifty Year Club met for the group's annual luncheon on May 23rd, 1967 during the ISMS convention. Dr. James Hutton, past president of ISMS, delivered the principal address.

The 1968 luncheon meeting—entitled Sesqui-centennial Celebration in Honor of the ISMS 50-Year-Club—will be held Tuesday, May 21. The number of Chicago Medical Society physicians expected to be honored—some 36—represents the smallest group in many years. Only 12 other physicians will be honored by their downstate county medical societies in 1968.

The total membership of the group now stands at 503 compared with 515 a year ago.

Matthew B. Eisele, *Chairman*

Peter C. Rumore Charles J. Weigel

Charles Vil Lee F. Winkler

CONSULTANTS:

Jacob E. Reisch Leo P. A. Sweeney

Physicians' Placement Service

During the past year, the Physicians' Placement Service was directly responsible for the placement of 20 physicians, the same total as last year. In consideration of the continued trend toward specialization and the increased call-up of physicians for the military service, we are well pleased with this total.

During the same period, the Sears-Roebuck Foundation assisted only 22 communities throughout the nation in obtaining physicians.

General practitioners were placed in the following downstate communities: Belvidere, Tuscola, Kewanee, Pontiac, and Okawville. In Chicago, general practitioners were placed in the groups headed by Arkell Vaughn, M.D. and T. S. Wright, M.D.

Specialists were placed in Belvidere, DeKalb, Downers Grove (2), Kankakee, Galesburg, Rockford and Chicago.

Part-time openings with the Bankers National Life Insurance Co. and the CB&Q railroad were filled and temporary placements in Princeton, a Chicago group and a private practice were completed.

Actually ISMS was responsible for additional placements which are unconfirmed as of this date. According to Mrs. Jane Swanson, Physician Placement secretary, it is becoming increasingly difficult to obtain verification of these placements by both the physicians and the communities.

Meanwhile the demand for general practitioners continues to increase by leaps and bounds while the list of physicians available decreases at an alarming rate. Despite our efforts—and those of the Sears Roebuck Foundation and the AMA Placement Service—the shortage of general practitioners in some rural areas becomes more serious every day. If the demands of the military forces are to be met—and the trend toward specialization in metropolitan centers continues at the present rate—it is only a matter of time before the situation becomes critical.

In view of our increased efforts to assist rural areas, the situation is extremely discouraging. However, the problem of rural placement is not unique to Illinois, for medical societies throughout the nation report similar problems.

The Placement Service has placed a total of 700 physicians on its mailing list during the past year as compared to 683 last year. Although 278 still receive our mailings of openings, 422 have been removed because they have either found locations or have neglected to answer our follow-up letters.

A tabulation of physician-applicants and opportunities listed as of March 1, 1968 follows:

SUPPLY AND DEMAND OF PHYSICIANS AND OPENINGS IN ILLINOIS AS OF MARCH 1, 1968

Specialties	Physician-Applicants	Openings listed
General practice	35*	206
Allergy	2	4
Anesthesiology	3	3
Dermatology	7	5
EENT	8	8
Internal Medicine	47	41
Neurological surgery	1	3
Obstetrics-gynecology	12	8
Ophthalmology	13	14
Orthopedic surgery	11	9
Otolaryngology	8	17
Pathology	11	1
Pediatrics	12	35
Psychiatry-neurology	9	5
Radiology	7	2
Surgery	57	15
Urology	15	9
Miscellaneous	34	37
	<u>292</u>	<u>422</u>

*does not include student loan recipients

It should be noted that although 206 openings

for general practitioners are listed as of March 1, 1968, only 35 general practitioners were registered. In 1956 there were 180 general practitioners on the mailing list and 100 openings.

In the past most of the openings for general practitioners were in small rural communities of 1,000 population or less. During the last year, however, there has been a decided increase in the towns of 5,000 and more population requesting our assistance. Many communities in the 1,000 and less group have discontinued their efforts to find a full time physician, realizing that the days of a resident physician in every small hamlet is a thing of the past.

There has been a marked increase in the number of physicians seeking associates during the past year—this applies both to the openings for general practitioners, as well as for specialists.

The Physicians Placement Service of ISMS has been publicized during the year by various media including its own *Illinois Medical Journal* and *PULSE*. Unfortunately the publicity seems to have resulted in an increased volume of requests from physicians looking for associates and from towns seeking additional physicians, rather than from physicians seeking locations—the group we would most like to reach.

It is hoped that ISMS members will use their influence with faculties and the administration of medical schools to urge them to consider increasing their enrollments and to undertake the expansion of their facilities—or to do whatever is necessary to bring about a solution to the problem.

COMMITTEE ON RELIGION AND MEDICINE

Since its inception in 1963, the Committee on Religion and Medicine has striven to find new methods of calling the public's attention to the essential inter-relationship that exists between physicians and clergymen in total patient care.

During the past year, we have been privileged to initiate two such programs:

1. Medicine-Religion radio series
2. The first Annual Medicine-Religion Awards Program

Radio Series

Created under the aegis of the Radio and Television Sub-committee, this 10-part series combines a pre-taped dramatic introduction and live interviews with local physicians and clergymen in the discussion of: abortion, contraceptive pills, mental retardation, organic transplants, suicides, narcotics addiction, and unwed mother, physical deformities, and sudden death in the family.

The series, which will be made available to stations throughout Illinois, is designed to call attention to medical-moral problems at the local level, and encourage the formation and participation of county medical society committees on religion and medicine.

Medicine-Religion Awards

Our new Medicine-Religion awards program will acknowledge contributions by Illinois physicians and clergymen utilizing the skills of their professions co-operatively to better achieve total patient care.

Nominees—representing one clergyman and one physician—will be selected by the county medical

society, its Committee on Religion and Medicine, or an ad hoc committee. Names and achievements of the nominees will be submitted to the ISMS Committee on Religion and Medicine by no later than Aug. 31, 1968. To enhance publicity value, the awards will be presented in Chicago in October. In addition, religion editors from newspapers across the state will be invited to attend the awards presentation and also participate in a special all-day program planned for them by the committee.

As far as can be determined, both the radio series and the awards program represent state medical society "firsts," and, it is hoped, will serve as national prototypes in creating greater public awareness of the necessary relationship between medicine and religion in patient care.

IMJ Articles

In its continuing program to create closer co-operation and understanding between physicians and clergy, your committee has carried out an ambitious information program.

Starting last June, nine articles have been published consecutively in the *Illinois Medical Journal*—many of them written by committee members—on the subjects: Doctors, Clergy and the Patient; Respect the Clergy; Your Patient May Desperately Need His Clergyman; The Hospitalized Religious Patient; The Office Patient and His Religion; The Religious Needs of the Catholic Patient; The Religious Needs of the Protestant Patient; The Terminal Patient and His Religion; and Who Shall Live, Who Shall Die?"

After publication of three more articles, the entire series will be distributed to hospitals and physicians throughout the state as a compendium of essential medical-religious information.

Exhibits Sub-Committee

One of the principal charges of this committee is the establishment of committees on Religion and Medicine at the county medical society level. During the past year, our most effective tool in achieving this goal has been the display of the AMA exhibit on medicine and religion at the ISMS annual convention.

A surprisingly large number of physicians from across the state registered at the exhibit, showed interest in initiating such a committee in their county, eagerly received the literature distributed and asked that more be sent them on a continuing basis.

Our entire committee has received a complete list of all registrants at the convention exhibit and is currently working out a systematized method of follow-up contacts to promote medicine and religion committee formation among the county medical societies.

Mr. Arne Larson, AMA representative to our committee on medicine and religion, has generously offered his services as field representative in contacting interested physicians throughout the state personally to accelerate this program.

Bibliography

Under the direction of Dr. Pfister, a bibliography of texts and pamphlets on the subject of medicine and religion has been compiled and is now available through the committee on request. Later in 1968, the committee plans to distribute this bibliography to a select mailing list of hospitals, physicians, religious organizations and individual members of the clergy.

The committee is especially indebted to Dr. J.

Ernest Breed, whose work in a consultant capacity has done so much to promote publication of the medicine-religion articles in IMJ; to Mrs. Sherman G. Arnold, for her imaginative efforts in organizing the awards program; to Dr. Bertram B. Moss who helped to initiate the new radio series; and to Dr. Pfister, for his exhaustive work in compiling the medicine-religion bibliography, and to Dr. Anna Marcus, for her leadership in arranging and manning the exhibit.

A special note of gratitude is also extended to Mr. Slawny, Mr. Schroder, Mr. Anderson and other mem-

bers of the public relations staff whose efforts have helped make possible the pioneering programs of this committee during the past year.

Robert Mendelsohn, *Chairman*

Lars Arden Almquist	The Very Rev. Msgr.
Eli L. Borkon	Armand J. Rotondi (M.D.)
Anna A. Marcus	E. T. Sorenson
Charles W. Pfister	Ernest Teagle
Paul S. Rhoads	William H. Whiting

CONSULTANTS:

J. Ernest Breed	Caesar Portes
Mrs. Sherman Arnold,	<i>Auxiliary Representative</i>

Scientific Program

Highlights . . .

Monday

ILLINOIS SURGICAL SOCIETY
ILLINOIS OBSTETRICAL & GYNECOLOGICAL SOCIETY
OCCUPATIONAL HEALTH
ALCOHOLISM
SECTION ON NEUROLOGY & PSYCHIATRY
SECTION ON SURGERY

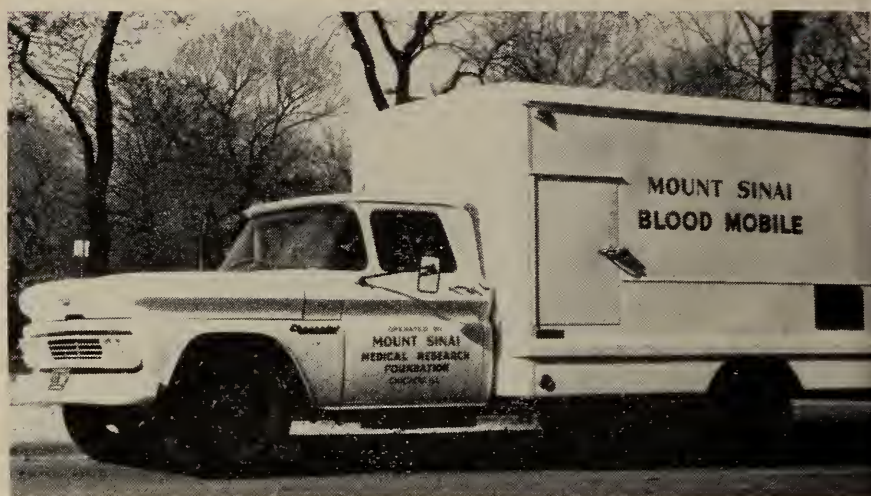
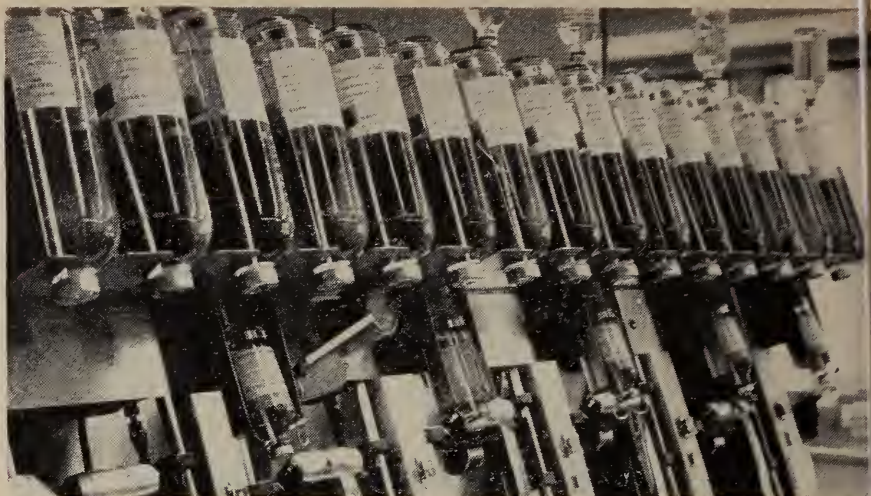
Tuesday

SECTION ON ALLERGY
DIABETES IN PREGNANCY & CHILDREN
SECTION ON PHYSICAL MEDICINE & REHABILITATION
SECTION ON PREVENTIVE MEDICINE & PUBLIC HEALTH
CONTINUING EDUCATION PROGRAM IN PSYCHIATRY
SECTION ON RADIOLOGY

Wednesday

SECTION ON E.E.N.T.
SECTION ON PATHOLOGY
SECTION ON PEDIATRICS
SECTION ON DERMATOLOGY
SECTION ON INTERNAL MEDICINE
ILLINOIS SOCIETY OF INTERNAL MEDICINE
PERIPHERAL VASCULAR DISEASE

This 3-day program is acceptable for 24 elective hours by the American Academy of General Practice.



Council on Scientific Advancement

The Council on Scientific Advancement consists of the chairmen of nine committees, most of which have annual reports appearing below. The council has met twice as of March 20 and has another scheduled meeting for early in May.

While the new council system has taken a little while to get used to, we have had some interesting discussions concerning a wide variety of scientific services offered by the society, and we hope to have

the mechanics working smoothly by the time of the annual meeting. One difficulty we have experienced is in scheduling meetings of sub-committees, committees, and the council in order to have all recommendations follow the proper channels and reach the Board of Trustees prior to its meetings. With a little more experience, we think this can be ironed out satisfactorily so that the council system will be operating efficiently.

COMMITTEE ON ALCOHOLISM

The committee has reviewed programs, present or projected, by other state medical societies, departments of mental health and public health. As expected, there was a range from no committee or thought of one, to an ongoing program with seminars and initiation of co-ordinated programming. The experience of the latter will be useful.

The committee has reviewed the "Manual on Alcoholism," newly published by the American Medical Association. It contains the contributions of well informed experts on alcohol and alcoholism. This committee believes that this will help the physician furnish service to the alcoholic by providing up to date, well organized, and practical information on all phases of management of his alcoholic patient.

The lower federal courts in several districts have ruled that chronic alcoholism is an illness; and that

a person so afflicted cannot be prosecuted for being publicly intoxicated. This means that health services and *not* legal agencies (police, jails, and courts) will be responsible for the treatment and rehabilitation of the chronic alcoholic. The Supreme Court will soon hand down a decision on this same issue. If the lower courts are sustained, the communities of Illinois will be confronted by a drastic change in its mode of dealing with the inebriate. Humanely, this action by the Supreme Court could spell the end of the disgraceful "drunk tanks" in local jails; and of the often disastrous neglect of these sick people. This committee is studying model legislation, designed to achieve proper and effective total management and prevention for chronic alcoholism. This legislation is sponsored jointly by the American Bar Association and American Medical Association.

The visitation to the Illinois Department of Mental Health Zone 1 Center in Rockford was most productive. The program of alcoholism control, under a full time director, is developing satellite treatment and management services that insure to a reasonable degree, professional supervision of the alcoholic. The zone center acts as a directorate for the lay and health professions involved in this program.

The committee unanimously approved initial involvement with official and voluntary agencies of the Chicago area which are concerned with the alcoholic. We have to date, contacted the responsible authorities of Cook County Hospital, the Alcoholism Treatment Center of the City of Chicago, the Chicago Police Department, the Hospital Planning Council for Metropolitan Chicago, and many others. The impact of the probable Supreme Court upholding the local courts must be of concern to the Illinois Hospital Association, the Chicago Hospital Council, the Illinois Association of Police Chiefs, as well as the Illinois Medical Society.

The committee has contacted the St. Louis, Missouri, Police Department and Dr. Joseph Kindis, concerning their program which involves a detoxification center at a local hospital and co-ordination with the local police and courts. A discussion of this co-operative program is considered to be important for a seminar at the May 1968 meeting of the Illinois State Medical Society. It would involve its medical director, police officials, as well as representatives from Illinois agencies such as hospitals, medical societies, police and government.

The final event which will be examined soon, is the recommendation by the President of the United States for the passage of the "Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 (H.R. 15281) (Appendix V)". This legislation would provide a beginning comprehensive program for alcoholism and the funds to carry it out.

Abraham Gelperin, *Chairman*

Charles L. Anderson	David J. Stinson
Richard Cook	John C. Troxel
Robert A. Moore	Frank J. Walsh
Jackson A. Smith	William H. Wehrmacher

CANCER CONTROL COMMITTEE

The Committee on Cancer Control recognizes its responsibilities in providing the physicians of Illinois with as much information as possible about the control of cancer, and is particularly anxious to find its proper role in the National Heart-Cancer-Stroke program.

Dr. Wright Adams, Executive Director of this program, known as the Regional Medical Program or RMP, was invited to sit down with the Committee and discuss the part the committee might play in the regional program. According to Dr. Adams, this role should be in the areas of education and communication.

Subsequently, the committee chairman made contact with the American Cancer Society in an attempt to establish liaison and prevent duplication of effort.

The committee is experiencing a certain sense of frustration in its efforts to obtain guidance from state and national organizations concerned with the problem of cancer control and has thus far established three principles for its own operation—that it should become immediately interested in:

1. Cancer chemotherapy and radiation therapy as educational projects.
2. Regular communication to ISMS members regarding developments in the Regional Medical Program.
3. Broadening the base of interest in the subject by bringing young physicians into its activities.

Thomas Sellett, *Chairman*

Kent W. Barber	Roland A. Kowal
Michael H. Boley	Rudolph G. Mrazek
Robert E. Field	Wilson R. Scott
Russell M. Jensen	Caesar Sweitzer
Andrew J. Toman	

CONSULTANTS:

J. Ernest Breed	Caesar Portes
Mrs. Richard Icenogle,	<i>Auxiliary Representative</i>

COMMITTEE ON CHILD HEALTH

A resolution calling for "medical examinations for school registration of kindergarten or first grade children . . . within 30 days of the third birthday" was referred to the Child Health Committee by the 1967 House of Delegates and received the following action:

The committee accepted the principle that the needs of handicapped children be recognized early enough for schools to provide for them, but it did not accept the wording of the resolution as referred because of problems involved in implementation. The sub-committee on school health was requested to make contact with Mr. Vernon Frazee, who is in charge of special education in the State Office of Public Instruction, to work out a voluntary reporting system for physicians. It was recommended that this procedure, with parental concurrence in writing, provide for physicians to examine children on or about their third birthdays and report disabilities to the local special education agency, which in turn would report such problems to the appropriate state agency.

It was reported to the committee that many foster children in the state are not receiving medical care because some doctors do not accept public aid patients. The committee urged the ISMS Board of Trustees to do whatever it could to get physicians to treat all children, including foster children even though they are receiving public aid. The February, 1968, (Vol. 133-2) issue of the *Illinois Medical Journal* carried an extensive interview with Dr. J. Keller Mack, Medical & Public Health Officer, in an effort to inform physicians of the plight of many of the state's foster children.

The committee will hold in abeyance recommendation on which catastrophic diseases should be referred to the Illinois Division of Services for Crippled Children until such time as adequate funds are available to expand the services of the division.

The committee approved a Relative Value Schedule developed by the Chicago Pediatric Society and the Illinois Chapter of the American Academy of Pediatrics and adopted the following amendment:

"It is recommended that the Child Health Committee develop a fee for the initial examination of babies to be adopted, insurance examinations for accident cases, insurance for normal newborns and other insurance for third party payments."

The committee re-affirmed its position that a physician should be present at all bodily contact contests or games and that his presence be required at every football game at the very least. The recom-

mendation is directed to both public and private schools and the committee is seeking Board of Trustees approval to send a letter to all school districts in the State urging compliance.

Ralph H. Kunstadter, <i>Chairman</i>	
Irving Abrams	Edward F. Lis
William J. Ball	Fred Long
Oliver W. Crawford	J. Keller Mack
Eugene F. Diamond	Franklin A. Munsey
Richard E. Dukes	Kenneth S. Nolan
Arthur W. Fleming	T. A. Palus
W. W. Fullerton	Leo G. Perucca
Edmond R. Hess	Ira M. Rosenthal
Howard R. Hone	Norman T. Welford
Eduard Jung	Walter M. Whitaker

Report of the Athletic Injury Clinic

The 3rd Annual Athletic Clinic was held at the stadium of the University of Illinois on Aug. 5, 1967. It was a full day meeting beginning at 9 a.m. and completed by 4:15 p.m.

The program this year was the best the clinic has ever put on and was probably the most instructive. It was done in spite of the fact there had to be a substitution of speakers at a late hour in place of the originally planned speakers. There were vacations that had not been anticipated at this time and there was one doctor on the program who was called into the military service. This had not been anticipated. However, all the subjects on the program were covered and some of it was done very well by pinch hitters, particularly by Dr. Peterson, who replaced Dr. Hamilton on orthopedic subjects. He also covered the neurological field, the original spot of Dr. McClosky who was unavoidably absent.

The attendance of the clinic was slightly less than the previous clinics because of apparently conflicting dates. This is still a problem of the clinic as to what day is best for the clinic and the program committee will consider this aspect in the planning for the 4th Annual Athletic Clinic.

W. W. Fullerton,
Chairman of the Subcommittee
on Athletic Injury of the
School Health Committee

MATERNAL WELFARE COMMITTEE

It is the hope of the Chairman of the Maternal Welfare Committee, in which I am joined by a great majority of the members, that some method can be perfected whereby greater access to the educational material developed at these meetings can be given to the general membership of the State Medical Society. Historically, the deliberations of the Maternal Welfare Committee have been conducted with the view of maintaining privacy and anonymity. It is believed that patient rights may be protected and still allow for dissemination of this educational material by means of the Journal of the State Medical Society. This matter has been placed before the Board of Trustees for its action, and has been favorably discussed by your chairman and the consultant in Obstetrics and Gynecology from the Illinois Department of Public Health. Such a project would not call for the expenditure of any funds.

During the calendar year of 1967 your committee held four meetings on the 12th of February, on the

20th of May, the 27th of August, and the 19th of October. At the first two of these meetings the studies of the 1966 case reports were included and a few of the early 1967 cases were coded. The last two meetings were devoted exclusively to protocols occurring in the calendar year of 1967. At the time of this writing (January, 1968) there remains a backlog of known cases in excess of 25. By way of some explanation, it should be pointed out that any death occurring within 90 days of the termination of a pregnancy is considered a possible maternal death. So the complete number of cases for consideration cannot possibly be known until sometime after the 1st of April every year. At this time, however, there appears to be no significant change in the maternal death rate.

As of mid-year there are some interesting trends that should be followed. Hemorrhage is down to the third cause of death, toxemia is second, and infection is first. The increasing prominence of infection as a cause of maternal death was mentioned by your chairman in the last annual report. However, hemorrhage, as of that time, was still the leading cause of death. It is, of course, entirely possible that with the completion of the entire year's studies, this trend may be reversed as the sample as yet is fairly small.

Your committee continues to be honored by requests for the findings of its deliberations by the physicians involved in the management. In all, 33 instances of inquiry or presence of the physician occurred during the study of the first 58 cases studied.

Other professional activities during the year consisted of participation in the program on "the medical implications of abortion" which, from all reports, was highly successful. Unfortunately, there was some diversion of funds from the Maternal Welfare Committee's appropriation into this area with the result that it appeared there had been some overexpenditure of funds by this committee; and this was not actually the case. Your committee was also requested to advise the Hospital Licensing Bureau relative to the appropriateness of husbands in the delivery room. The co-operation of your committee in preparing forms for a pilot study to be conducted by the American College of Obstetrics and Gynecology to determine the facilities available to women in labor was happily granted.

Your chairman was requested to appear before the State Legislature Reference Committee relative to the appointment of a commission to study abortion laws as well as to testify relative to the necessity for changing the abortion laws. The first of these measures passed and was vetoed by the Governor. The second failed to secure legislative approval.

Attendance by members of the committee continues to be excellent. No district has failed to be represented more than one time. In several instances both delegate and alternate have been present; and in almost every instance when the delegate could not be present, he arranged for his alternate to attend.

The continued presence of Dr. Webster, the house staff of Cook County Hospital, and Dr. Szanto of the Hektoen Institute adds greatly to our meetings. In addition, your chairman would be remiss not to publicly acknowledge the great service rendered the committee by Dr. Rendok, consultant in Maternal

Welfare, and Dr. John Louis of the Hematology Section of the Stritch School of Medicine.

It is our hope that the favorable consideration of the Board of Trustees of the recommendation to give wider circulation to the educational aspects of material developed by this committee shall result in greater service to the parturients of Illinois and their offspring.

Robert R. Hartman, *Chairman*

V. B. Adams	Melvin Goodman
Hubert L. Allen	Charles D. Krause
Donald M. Barringer	William R. Larsen
Jack D. Brodsky	Harry L. Lewis
William W. Curtis	Hubert Magill
George E. Fagan	John J. McLaughlin
Frederick H. Falls	Paul A. Raber
Hugh C. Falls	Berry V. Rife
William J. Farley	Donald R. Risley
Lewis J. Foley	James B. Stotlar
Ralph L. Gibson	Charles H. P. Westfall

CONSULTANTS:

John Lewis	Williard C. Scrivner
Donaldson F. Rawlings	Augusta Webster
John H. Rendok (dec.)	Thomas R. Wilson
Franklin D. Yoder	

COMMITTEE ON MENTAL HEALTH

No report submitted.

John R. Adams, *Chairman*

E. Eliot Benezra	Richard J. Graff
Irving Frank	John H. McMahan
Walter P. Plassman	

Harold M. Visotsky, *Consultant*

Mrs. Thomas Tourlentes, *Auxiliary Representative*

COMMITTEE ON NARCOTICS

Your Committee on Narcotics and Hazardous Substances continues to pursue its responsibility to:

1. Study, research and disseminate educational information on narcotics and hazardous substances.
2. Recommend acceptable measures for the control of distribution of narcotics and hazardous substances.
3. Co-operate with official and non-official agencies in all matters pertaining to this subject.

A National Symposium on Psychedelic Drugs and Marijuana is scheduled for April 10 and 11. A program including the nation's most prominent experts on psychedelic drugs and marijuana has been arranged by your committee, and guests from the U. S. Bureau of Narcotics, Bureau of Drug Abuse Control, Illinois Department of Public Safety, Cook County Circuit Court, and the National Institute of Mental Health.

The program is multidisciplinary in nature with leading figures from the fields of sociology, medicine, theology and law participating. Its purposes are to educate the experts in related fields, to educate the public, and to compile a useful reference on the subject of narcotics. The general goal of the symposium will be to reappraise present attitudes and approaches from all viewpoints in order to devise the most intelligent and effective methods of confronting this growing problem.

The five narcotic task forces set up as a by-product of the 1966 National Conference on Narcotics will insure coverage and continuity following the 1968 symposium.

The Committee on Narcotics and Hazardous Substances concluded a pilot program to inform high school faculty members about psychedelic drugs and narcotics. This program consisted of a four-part seminar developed by the committee in co-operation with the New Trier, Evanston, Niles, Glenbrook and Highland Park School Districts.

The first session was presented Sept. 27, 1967, at New Trier High School West Campus, and featured an orientation discussion of the psychology and pharmacology of drugs by Dr. Jerome Jaffe, assistant professor of psychiatry at the University of Chicago Medical School, and Dr. David M. Slight, a practicing psychiatrist and member of the senior attending staff at Henrotin Hospital and myself.

The second session was held on Oct. 17, 1967, at Glenbrook High School with the sociological aspects of drugs being discussed by Dr. Thaddeus Kostrubala, assistant professor of psychiatry at Northwestern University Medical School, and Dr. Daniel X. Freedman, professor and chairman of the Department of Psychiatry at the University of Chicago Medical School.

The third session, held on Nov. 8, 1967, at Evanston Township High School, involved the legal and cross-cultural aspects, with discussion by Circuit Court Judge Kenneth R. Wendt, Dr. Kermit Mehlinger, Psychiatric Consultant to Chicago Municipal Courts and Dr. Kostrubala.

The final session, Nov. 29, 1967, at Niles Township High School West, was devoted to a review by all participants.

The chief purpose of this program was to inform key faculty members of the scientific, social, and legal aspects of the use of drugs and marijuana so as to be able to intelligently confront misguided and misinformed students.

Merrill Flair, M.D. of Northwestern University and your chairman attended each session to evaluate the program in attaining its chief purpose. Similar programs may be held in other schools.

During the 75th General Assembly your committee was actively interested in several pieces of legislation. The Uniform Drug and Cosmetic Act was amended by House Bill 4 so as to include under the definition of "dangerous drugs" the drug known as LSD and other hallucinogens. House Bill No. 200 was also passed to exclude paragonic from the list of exempt narcotic preparations. Your committee chairman appeared as a witness before the Public Welfare Committee in support of these two bills.

Also passed and signed into law was the Drug Abuse Control Act, the amendments to which were worked out with the Chairmen of your Narcotics and Legislative Committees.

Your committee is optimistic that its efforts are contributing to an intelligent and reasonable approach to the problem of drug abuse.

Joseph H. Skom, *Chairman*

Raymond E. Anderson	Abraham Gelperin
Richard Eisenstein	Kermit Mehlinger
Edwin Feldman	David M. Slight

COMMITTEE ON NUTRITION

Our Nutrition Committee has had a very successful year in 1967. Initial acceptance of the committee's proposals for emphasis on education in the use of food stamps among the indigent led to adoption of

a statement of policy by the House of Delegates at last year's convention.

In October the Tenth Annual Conference on Nutrition in Medicine was held in Bloomington. Co-sponsored by the Illinois Nutrition Committee, with additional backing from the Illinois Department of Public Health and the McLean County Medical Society. The conference was well attended (about 150) and was exceptionally well received.

The initial planning meeting for 1968 has recently been held and plans are underway for special study topics, among which are school lunch programs, PKU testing, Salmonella and Shigella epidemiology and pesticides and insecticides.

While not initially involved in the presentation of a series of lectures on clinical nutrition presented in Illinois by the AMA, the 1968 portion of the lectureships program will be promoted by the Nutrition Committee. The committee attended such a lecture at the SIU Edwardsville Campus on Feb. 19, 1968. Featured speaker was Dr. Jack Metcalf, Pediatrician, Chicago Medical School and Michael Reese Hospital. Future programs of this nature are planned and the committee is to be involved in the presentations.

An invitation has again been extended for ISMS to collaborate with the Conference on Nutrition in Medicine in 1968. Plans for this will be formulated in the near future.

The committee has received permission of the Board of Trustees to again co-sponsor the conference as we have the past 10 years. Other sponsors will be the Illinois Nutrition Committee, the State of Illinois Department of Public Health and the local county medical society.

The chairman represented the Illinois State Medical Society at a Symposium on Therapeutic Nutrition, Dec. 4, 1967, University of California, Davis, sponsored by the Council on Foods and Nutrition American Medical Association and the University of California, Davis.

Plans are being made for a 1969 co-sponsored meeting, to be held in Chicago, of the Institute of Food Technologists, the Chicago Nutrition Society and the Committee on Nutrition of the Illinois State Medical Society. The two such meetings held in 1962 and again in 1966 were very successful scientific meetings.

Paul A. Dailey, *Chairman*
A. A. Filek James Litsey
Eugene Johnson Harvey D. Scott
Paul R. Cannon, *Consultant*

PUBLIC HEALTH COMMITTEE

The Public Health Committee is a new committee and in the first few months of its operation has acted principally as a holding committee for its four subcommittees. Each of these has been active and has developed the following areas of thrust.

1. The Subcommittee on Environmental Health developed an aggressive, carefully thought out statement on water pollution which has had widespread acceptance and was presented at a four state conference in January of 1968. It is also urging physicians to include environmental health as they become active in comprehensive health planning at all levels.

2. The Subcommittee on Laboratory Evaluation is developing a strong resolution clearly stating that

blood, blood products, and human organs when used in human beings represent services, not pharmaceutical products. It is also making a penetrating study of the use of substandard laboratories by physicians.

3. The Subcommittee on Occupational Health is developing topics for the symposium at the ISMS 1968 meeting including several interesting topics such as "Emergency Care in Industrial Medical Departments", "The Coronary Suspect", and "Employees with Psychological Problems".

4. The Subcommittee on Tuberculosis is strongly backing the tuberculin testing program and especially for pre-school children. This committee warns physicians not to de-emphasize the infectious aspects of tuberculosis regardless of statements now appearing in the news media.

With the subcommittees well underway, the Public Health Committee now addresses itself to developing a penetrating liaison with the federal, state, and local comprehensive health planning groups and with a program to strongly stimulate physicians to become active in all phases of this planning and especially at the local level.

Thomas P. de Graffenried, *Chairman*
Edward C. Holmblad Clarke W. Mangun, Jr.
Fred Long Charles K. Petter
Grover L. Seitzinger

Sub-Committee on Environmental Health

Activity During the Past Year

During the year, an article on the significance of water pollution in Illinois was developed by the committee which suggested activities for medical societies and individual physicians in the effort to improve and preserve the quality of public waters.

The Council on Scientific Advancement and the Board of Trustees adopted it as an official policy of the society. The article is to be published as a committee statement which has been adopted by the Board of Trustees.

A summary of the policy statement on H₂O pollution was read before the Four State Conference on Water Pollution on Feb. 5, 1968. The conference was called by Stewart L. Udall, Secretary of the Interior, on the request of Gov. Otto Kerner and involved the States of Illinois, Wisconsin, Indiana and Michigan and was concerned mainly with pollution of Lake Michigan.

The support of the committee was offered for passage of the \$1 billion bond issue for clean water, clean air and recreational purposes.

The committee feels keenly the loss of Dr. Edward Press as its chairman. His ability and leadership enabled the committee to make important contributions to health in Illinois, including such things as legislation for the elimination of flammable fabrics which eventually led to national legislation, and pointing up the dangers of medical uses of lasers. The committee wishes him well in his new responsibility as State Health Officer, Oregon State Board of Health.

Proposed Future Activities

The committee proposes to develop a position paper on air pollution which can be considered by the Council on Scientific Advancement as the basis for a policy statement by the society. This is a first priority

because of the increasing severity of air pollution, the increasing concern of citizens and all levels of government about the problem and the need of practicing physicians for better information on the health effects of air pollution.

Because of the availability of more safety devices and features on new automobiles, the committee plans to study their value with the objective of developing recommendations to physicians for their consideration in purchasing a car for professional use. The recommendations would include features for safety, dependability, and utility specifically for physicians. Using these recommendations supplemented by their own judgment, practicing physicians might advise their patients and members of the general public as appropriate, so that a possible reduction in injuries and deaths might result.

The committee will support activities of the special committee for passage of the State of Illinois bond issue for control of H₂O pollution, air pollution, and recreational facilities.

As the State of Illinois and the society become more involved in "Partners in Health," and Comprehensive Health Planning, the committee will hope to communicate with physicians involved to alert them to the importance of including environmental health in comprehensive health planning and offer its resources.

The pamphlet "Danger Laser Light—A Manual of Safety Precautions for Laser Systems" has been popular and because the supply is depleted the committee plans to review and update the publication for republishing. The objective will be to keep it as a useful information piece for the practicing physician.

Clarke W. Mangun, Jr., *Chairman*

Howard C. Burkhead	Robert J. Maganini
Edward C. Holmblad	Grover L. Seitzinger
John S. Hyde	Joseph S. Skom
Ralph H. Kunstader	Frank D. Yoder

THE WATER POLLUTION PROBLEM

The Help of Physicians is Needed

The Priceless Miracle of Lake Michigan

A little more than 70 per cent of the earth's surface is covered with water. Of this enormous amount of surface water, less than 1 per cent is liquid and fresh.¹ The Great Lakes system is the largest body of fresh water in the world and contains about one-third of all the fresh surface water on earth. Lake Michigan has 21 per cent of all the water in the Great Lakes system which amounts to 7 per cent of all the fresh surface water in the world. The population that uses this water in Illinois is approximately 1.2 per cent of the world population.⁵ How fortunate we are to have this water at our disposal. The Chicago shore of Lake Michigan is the longest length of fresh water shore in the world that is the border of a major city yet sufficiently unpolluted to provide recreational use of the water.

POLLUTION IS DESTROYING LAKE MICHIGAN

What Has Happened to Lake Michigan

In 1900, the Chicago River was reversed, so that sewage was drained into the Illinois River instead of the lake. This out of the Lake and down the River use of water was mainly responsible for preserving the quality of the water in Lake Michigan,

but there were limitations. Because the Great Lakes are an international waterway, a complicated and often controversial treaty was signed with Canada in 1909, limiting the amount of water that Chicago could divert from Lake Michigan and establishing priorities for the use of Great Lakes water. It is commendable that domestic and sanitary purposes were given priority over use of the water for navigation, power, irrigation and industry.

Since the signing of the treaty in 1909, Canada and the United States have worked long and hard at the complicated problem of the preservation and wise use of Great Lakes water. However, the irresistible demands made by population growth, urbanization, industrialization and economics have exceeded the resources available to pollution control agencies to preserve the high quality of Lake Michigan water. The population in Illinois that uses water from Lake Michigan has grown from 6,292,633 to 8,525,737 between 1940 to 1960 which is a 35.5 per cent increase. Industrial use of Lake Michigan water by Illinois has compounded rapidly and now amounts to 4.5 billion gallons per day. Is it any wonder that Chicago has the world's largest municipal water treatment plant?

What do Illinois communities and industries do with the enormous amount of sewage and industrial waste water that they generate each day? The Metropolitan Sanitary District, which is the largest processor of waste water in Illinois, says that its treatment processes are 90 per cent effective and that the water from their treatment plants goes into the Chicago Sanitary and Ship Canal and eventually into the Illinois River.

Information from the Federal Water Pollution Control Administration indicates that nearly 99 per cent of the pollution of the lake is coming from sources *outside* the State of Illinois and that pollution of the lake from these sources has increased.⁵

What Is Being Done?

The increasing pollution of Lake Michigan has alarmed and vexed Illinois citizens. Many groups, including the Illinois State Medical Society, and all the mass media of communication, have recognized the importance of preventing the pollution of Lake Michigan and are strongly on record with their views. Newspaper coverage has been outstanding. Passage of the Water Pollution Control Act² and the Oil Pollution Act by the 89th Congress,³ and the Lake Michigan Anti-Pollution Bill by the State of Illinois, have strengthened and made more effective the great effort that government has made and is making to prevent pollution of the lake. During the last 10 years studies by Federal and State agencies, have developed more information about the Great Lakes than about any other large body of fresh water in the world. Armed with documented evidence of pollution, and reinforced by an informed and aroused public, elected officials of all levels of government are advocates of public programs for the prevention of the pollution of Lake Michigan.³

All of these events have strengthened the programs and accelerated the progress of government agencies, private organizations, and industry in stopping the pollution of Lake Michigan. It has also increased research in water pollution technology and its application.

Does all this mean that the elimination of pollution of Lake Michigan and Illinois Public Waters will now be accomplished?

IT DOES NOT!

Assuming that all the needed technology were available, we have no way of knowing whether the public as consumers and tax payers are ready, willing and able to pay the economic price directly and indirectly involved, or to make the changes in their living habits that may be required.

It is easy to blame industry as the "bad guys" but this is unfair since the majority of Illinois industries as good corporate citizens, have spent and will spend in the future, huge sums for pollution control. Water is the number one raw material of industry and enormous amounts of it are used in such basic industries as steel production, oil refining and the production of paper and chemicals. Both domestic and industrial users dispose of waste water in the least expensive manner which may not be consistent with pollution control.

For industries as well as communities and individuals that fail in their obligation to keep public waters clean, Federal and State laws provide for enforcement of anti-pollution measures. Major progress is being made, but pollution has a head start and procedures for enforcement require much time before water is finally "cleaned-up".

How Physicians Can Help

What does all this mean to a practicing physician and what should he do about it?

1. *As an individual citizen*—he can and should give carefully considered support to water pollution control as a public policy and avoid doing things as an individual that pollute public waters.
2. *As a professional person*—with a scientific education, and serving as a community leader, he can inform people that clean water has a cost that needs to be paid. Joining in the clamor for clean water is easy, but supporting higher rates for water or sewage treatment, or voting higher taxes for them requires a courageous and understanding citizenry.
3. *As a practicing physician*—he has the crucial responsibility for the diagnosis, treatment, and prevention of disease among his patients and giving medical guidance and support to public health programs. While there is cost to the elimination of water pollution, there are health implications which take priority over all other considerations. The effects of some pollutants might appear in drinking water have been identified, and clinical and pathological findings described. These include nitrates from wells, some insecticides, such as DDT, sodium, and fluorides.

However, there is a broader kind of medical responsibility about which much less is known, but which could be of tremendous importance.

Solving a water pollution problem can be an extremely complex process with hundreds of factors influencing the decision of how to do it. The problem of disposing of dredgings from Indiana Harbor seemed to be solved by the plan to dump them into two steel company land fills at the Indiana shore. The Indiana Stream Pollution Control Board ordered the dumping stopped because it was a "serious

threat" to certain municipal water supplies.⁴ It seemed for a time that pollution of one body of water had been "traded" for another.

"Trades" made in order to control pollution can become very complex. For example, the sewage treatment plant of the Metropolitan Sanitary District at Stickney, Illinois incinerates some of the solids removed from sewage. Could this be trading water pollution for air pollution? The Chicago Housing Authority uses wet scrubbers on the exhaust gasses of some of their trash incinerators to reduce air pollution. The water with its suspended particles and dissolved materials is flushed down the drain. Is this trading air pollution for water pollution? Pollution "trading" between land, air and water tends to be common and there are skilled, knowledgeable, and dedicated people concerned with the ecology of these interfaces.

The effect on health from pollution control methods and from thousands of technological advances, are largely unknown or poorly understood. Practicing physicians in a general or any speciality practice may be the first or only source by which disease caused by ecological "mistakes" or advances in technology are identified. Instead of "the bug that is going around", a skilled physician may suspect or identify a pattern in the history, symptoms, or findings of some of his patients that could be environmental in origin. To "check out" a hunch a physician can get help from the Illinois Department of Public Health*.

As technology advances there will be changes in our environment from pollution and pollution control. More information is needed about the health effects of these changes. Medical information is essential for helping to make decisions on how best to control pollution and other environmental health hazards. Practicing physicians are the primary source of this important information.

*Franklin D. Yoder, M.D.

Director of Illinois Department of Public Health
Room 503, State Office Building
Springfield, Illinois 62706
Phone: 217-525-4977

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4. Newspaper articles, Tribune. "Save our Lake."
5. Personal communications. W. Poston, Information Officer Federal Water Control Administration, Great Lakes Program, Chicago, Illinois.

Sub-Committee on Laboratory Evaluation

No report submitted.

Grover L. Seitzinger, *Chairman*
Ronald C. Jessen Jack Williams
 Hans Willuhn
CONSULTANTS:
Gerald Dean James B. Hartney

Sub-Committee on Occupational Health

The Occupational Health Committee presented its third annual symposium May 22, 1967, during the annual meeting of the Illinois State Medical Society. The general subject was "Industrial Health" and papers were presented by Arthur E. Sulek, President-elect, Central State Society of Industrial Medicine and Surgery, speaking about "Professional Industrial Medicine"; Dr. James Staron, Medical Director, Electro-motive Division, General Motors Corporation on "Job Placement in Industry"; A. H. Movius, M.D., Assistant Medical Director, Hawthorne Works, Western Electric Corporation, on "Women in Industry"; Vladmir Urse, M.D., Superintendent, Cook County Hospital, Mental Health Clinics, "Emotional Problems in Industry"; and Stella L. Bruggen, R.N., writer-lecturer on eye health, "Contact Lenses in Industry."

Other speakers were John A. Palese, M.D., Area Medical Director, Liberty Mutual Insurance Co., "Modern Preventative Industrial Medicine"; Charles Asbury, Medical Director Caterpillar Tractor Co., "Health Services for Small Industrial Employee Groups," and Jerry Siedlecki, Assistant Director, Department of Occupational Health, American Medical Association, "Outlook of Industrial Hygiene in Illinois."

Some of these papers were abstracted and published together as a symposium in the January, 1968, issue of the *Illinois Medical Journal*.

Proposed subject matter for the 1968 program includes: Emergency Care in Industrial Medical Departments, Immunization in Industry, Eye Health in Industry, The Coronary Suspect, Employees with Psychological Problems, Care of Valuables of Unconscious Persons, and Current status of Various Immunization Programs.

The chairman and members of the committee have kept abreast of developments in the field of occupational health by attending local and national meetings on the subject and have made themselves available to county medical societies through the ISMS Speaker's Bureau, to bring these developments to the membership.

Edward C. Holmblad, *Chairman*

Charles Asbury
George H. Irwin

Arthur E. Sulek
Chester R. Zeiss

Sub-Committee on Tuberculosis

Tuberculosis is not a dead issue as many think; it is adversely affecting the lives of many people. This significant statement bears repeating and emphasis to bring to the attention of the practicing physician and the general public the need for control of this highly infectious, disabling disease.

The Sub-Committee on Tuberculosis addressed Dr. Franklin D. Yoder, Director of the Illinois Department of Public Health, asking him to do all within his power towards implementation of legislation based on the Report of the Governor's Tuberculosis Advisory Committee. The sub-committee endorsed the recommendations and indicated their anxiety to see legislation enacted.

All physicians are encouraged to make a tuberculin test part of the school health record of every child in Illinois at the time of school entry and

thereafter as procedures are established between health departments and school officials. The sub-committee recommends, that:

As in Michigan and Indiana, Illinois should make the tuberculin test mandatory in all pre-school examinations.

It has been noted that some hospitals and laboratories are lax in reporting cases of tuberculosis. Public Health regulations specifically state that tuberculosis is a reportable disease. Physicians are legally and morally responsible for such reporting. A letter from Dr. Yoder to all hospitals and laboratories emphasizing this would be in order.

Discussion of laboratory procedures has evinced the observation that more and better specimens of sputum should be studied by concentrate smear examination and more specimens of sputum (spontaneous and heated aerosol induced) and gastric lavage specimens should be sent to State Laboratory facilities to make this possible. All physicians are encouraged to consider this.

Routine chest films on all hospital admissions are definitely a must. While the procedure may not be as productive as radiologists would like it to be, it is capable of discovering active tuberculosis in many cases.

We cannot belittle the infectiousness of tuberculosis. We must at all times be aware of the need to alert the public to the seriousness of this affliction.

The tuberculosis sub-committee shall continue to serve as a source of information on tuberculosis matters for the state society. It shall continue to evaluate available information and make recommendations for ISMS policy. It shall cooperate with institutions and voluntary health agencies in disseminating information on tuberculosis to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

Charles K. Petter, *Chairman*

Otto Bettag	Hiram T. Langston
Kenneth G. Bulley	David F. Loewen
John C. Devlin	Karl H. Pfuetze
Charles W. Gray	William P. Standard
Clifton Hall	George C. Turner

CONSULTANTS:

William B. Adams	Edward A. Piszczek
Darrell H. Trumpe	

RADIATION COMMITTEE

The Radiation Committee of the Illinois State Medical Society shall serve those physicians in Illinois who use radiation as a modality of diagnosis or therapy; and, will assist those who have problems in radiation as it relates to the general health of the public.

This past year, your committee met with the Illinois Radiation Protection Advisory Committee seeking a better understanding of the specific rules and regulations of our state. No action is sought by the Radiation Committee from the Illinois State Medical Society, as a result of this meeting.

The Radiation Committee shall continue its meetings when called by the Chairman if problems related to radiation are called to the attention of the Committee.

Howard C. Burkhead, *Chairman*
 Abraham H. Cannon James J. Nickson
 Stephen L. Casper Hyman R. Osheroﬀ
 Robert W. Donnelly Norman R. Shippey
 J. Homer Goodlad Raymond B. White
 Stuart P. Lippert

CONSULTANTS:
 J. Ernest Breed Carl E. Clark

COMMITTEE ON REHABILITATION SERVICES

No report submitted.

Henry B. Betts, *Chairman*
 Brian Huncke Joseph A. Petrazio
 Joseph L. Koczur Arthur Rodriguez
 Howard Schneider

CONSULTANTS:
 Frank J. Jirka, Jr. W. T. Liberson
 Reuben R. Wasserman

ILLINOIS DEPARTMENT OF MENTAL HEALTH ACCELERATION OF INTENSIVE TREATMENT PROGRAMS

Ten years ago, the chronically mentally ill languished in dismal and dank hospital wards caught up in maelstroms of personal fears, anxieties and depressions. For the majority of patients, treatment was limited to basic custodial care. Elderly patients were made as comfortable as possible; but faced only the prospect of a physical illness severe enough to put an end to their mental anguish. Many of them had been in a hospital for years.

Mental disorder is not a terminal illness. For younger patients the future was even more grim. Entering the hospital for the first time, these patients usually were assigned to treatment wards where a few trained personnel struggled valiantly to bring them back to a functioning level. If a patient did not respond immediately to treatment, he frequently was relegated to a custodial care ward, abandoned by family, to spend ten, twenty, thirty years separated and submerged from the community.

Today this hopelessness is a thing of the past. Dramatic breakthroughs in treatment techniques, drug therapies, and an enlightened and concerned community are accelerating, to an astonishing degree, the recovery of patients at one time diagnosed as beyond reach.

The Department of Mental Health goals of treatment for all and despair for none are emerging in the form of intensive, short term inpatient care supplemented by highly structured outpatient and after care services which penetrate into the very core of the community. Substantial increases in quantity and quality of trained personnel, and the creation of innovative zone and subzone facilities and programs are successfully treating many people with mental disorders and restoring them to productive capability before these disorders can become deep seated psychosis. Results are increasingly significant—resident populations of institutional care facilities are decreasing steadily, despite increased admissions. Now, average daily populations at state mental hospitals are 35 percent reduced from five years ago.

Establishment of effective treatment programs were possible because responsible citizens were willing to commit vast new monies to abolish custodial concepts in favor of therapeutic and professional

treatment. Passage of a \$160 million dollar bond issue in 1960 provided the impetus for renovation and improved staffing of traditional department facilities. Further, the referendum provided funds for the construction of new community zone centers to serve as a nucleus to develop creative new services in hundreds of communities throughout Illinois. Significantly, three years later, the federal government appropriated start-up funds so that services similar to those already being developed in Illinois could be duplicated across the country.

New Services

As a primary objective, the Department of Mental Health, under the leadership of Harold M. Visotsky, M.D., Director, is seeking to hasten the establishment of new services in many Illinois communities. These services include emergency services, day care centers, and outpatient group and individual therapies. Vocational rehabilitation services to assist recovering patients with resocialization, employment and community living problems also are being intensified.

Thirteen state hospitals and five schools for the retarded today are therapeutically designed, administered and equipped to provide effective treatment for Illinois citizens in need of long term care which cannot appropriately be provided in the patient's own community. Eleven hospitals have been accredited by the Joint Commission on Hospital Accreditation, a joint commission of the American Medical Association and the American Hospital Association. To receive certification, hospitals must meet rigid standards relating to treatment provided and quality and cleanliness of the physical plant and services.

Zone Centers

To meet the challenge of Illinois' burgeoning population, with its ever increasing need and demands for service, the Department of Mental Health has been decentralized and divided into eight geographical zones. During the middle of this decade multi-million dollar zone center facilities were constructed in the six northern zones of the state. The thrust of the zone centers will be to accelerate even further, the establishment of new community facilities throughout the geographical area served by the zone. The zone centers themselves will serve as a nucleus to provide diversified outpatient and after-care services, consultation for planning, construction, staffing and programing of new community agencies, and in addition, will provide limited short term intensive inpatient treatment.

Inpatient care was initiated at the Charles F. Read Zone Center in Chicago in 1966. Similar services were opened in 1967 at Madden Zone Center in Chicago, and in Rockford, Peoria, Decatur, Champaign and Springfield. Through early intervention at time of crisis, the zone programs seeks to eliminate the necessity for long term hospitalization. Where sufficient staff has been acquired to provide full treatment programs, such as the Winnebago-Boone unit of the Singer Zone Center at Rockford, and the Effingham unit of the Meyer Zone Center in Decatur, admissions to professional care facilities has been more than 50 per cent reduced.

The zone centers were not designed, nor are they equipped, to serve as the panacea for all types of mental disorders. Rather they are established to coordinate all public mental illness and mental health services available to citizens of the state, to assure

that each citizen receives the most effective treatment possible. Wherever possible the patient is not removed from his home and family. With the impetus of additional funds and increased staff, and with substantial assistance of zone staff, the hospitals are returning more patients to their homes than are being admitted.

Geriatric Services

Another priority objective of the department is the development of competent new programs to serve the large geriatric populations of state facilities. Many of these patients, suffering relatively minor degrees of emotional disorder, are responding to new treatment and drug techniques and are successfully being placed in more appropriate facilities if long-term care is indicated. Other long-term patients are returning to their homes and families and are functioning as productive citizens capable of living independent or nearly independent and creative lives.

Several major mental health bills were enacted by the 75th General Assembly and approved by the Governor in 1967. Of particular import was Senate Bill 1349 which substantially revised the 1963 Mental Health Code. The Revisions became effective Jan. 1, 1968, and were primarily designed to simplify and ease admission processes and provide increased civil rights protection for patients.

Perhaps the single most important section in the 1967 Revision is the redefinition of "in need of mental treatment." With this change comes statutory recognition that mental hospitals are not to be used to confine objecting citizens solely because they happen to have some form of deviant behavior. Persons now can be involuntarily detained only on grounds that can be measured—that of physical injury to self or others or inability to care for self.

With the new Code, as under the current law, no patient can lose his civil rights solely by virtue of hospital admission. Under changes in the new Code, emergency detention without a physician's certificate must be obtained within twenty-four hours. These provisions allow immediate hospitalization and now place responsibility for ultimate certification on the person requesting admission.

Mental Health Planning Board

Other major legislation created as a statutory body, the Illinois Mental Health Planning Board. The Board is comprised of two senators, two representatives and ten public members. The powers and duties of the board are for development of continuous, long range planning to provide a comprehensive, statewide mental health and mental retardation program.

Senate Bill 1371 amends an Act relating to community mental health facilities and services, including facilities and services for the mentally retarded, and provides state grants in-aid to assist local communities in establishing and operating such facilities and services. The bill authorizes the department to set standards of eligibility.

Senate Bill 1414 revises a previous statute which empowers local county boards to establish hospitals, to acquire lands and grounds and to erect, maintain and equip buildings. It also authorizes treatment of non-residents, establishment of reasonable charges therefor and makes other changes.

The department's powers and duties are expanded to include, at the discretion of the director, a provi-

sion to provide patients under department jurisdiction with monetary remuneration, or other incentives on a graduated scale for work performed as part of their training for future employment. One hundred thousand dollars in mental health funds was included in the department's appropriation for this purpose.

The department also was authorized to make grants in-aid not to exceed 30 per cent of the construction and equipment costs for mental retardation facilities and community mental health centers; \$1,500,000 in mental health funds was included in the department's appropriation.

Senate Bill 489 revises previous legislation to broaden authority to place persons who are on department programs in other facilities which may be considered desirable. This will permit more flexibility and placements will not be restricted to "patients in any institution under the jurisdiction of the department," as the former statute provided. The Department of Mental Health may pay the actual cost of residence, treatment or maintenance in facilities outside the department and may collect such actual costs or a portion thereof from the patient, the estate of the patient or responsible relatives.

Senate Bill 950 provides \$54 million dollars for the construction and staffing of six new mental retardation facilities in the Northeast quarter of Illinois. These facilities will be designed to provide a full range of treatment and care services for mentally retarded in the heavily populated Chicago metropolitan area. Construction and staffing of the new mental retardation facilities will allow inpatient care and treatment services to be provided for the patients currently on department waiting lists, and will substantially relieve overcrowding at Lincoln and Dixon State Schools where the majority of Chicago residents presently are served.

Short-term and long-term Department of Mental Health objectives will continue to stress the development of comprehensive community mental health services, seeking to provide effective and intensive treatment for the mentally disoriented in their homes if possible, and if not, in familiar environments, so disruption to their lives occurs to the least possible extent.

The paradox of short-term, but costly, treatment being ultimately less expensive than long-term care has been borne out by national studies. The economy of keeping people productive and functioning in the community, as opposed to "warehoused" in tax supported facilities is easily understandable. The department, in the future, as in the immediate past, will expend every energy at its disposal to assure that citizens of Illinois are provided opportunity to live useful and purposeful lives, assisted, when necessary, with the most advanced and effective treatment programs known if mental illness or retardation causes a disorder in their activities.

Harold M. Visotsky, *Director*

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Data Processing

The inherent slowness in manual methods of editing, posting, indexing, cross-referencing, filing, updating, retrieval, report generation and mathematical and statistical calculations has made it necessary for the department to explore ways in which elec-

tronic data processing can be used to handle the rapidly expanding volume of health and health related data.

The result has been the creation of the *THIS in Illinois* project which will centralize computer-based demographic, health resource, status and population-need data through a long-range total health information system plan utilizing the Department's Bureau of Data Processing.

The *THIS* project is aimed at developing a more effective characterization of multi-faceted health problem areas and an improved allocation of both private and public resources to service the existing needs.

With the development of *THIS* in Illinois, each county and city in the state will be provided all available information for health program planning and the evaluation of new and existing health activities.

Dental Health

A significant step forward in the battle against dental caries came with the passage of the compulsory fluoridation law by the General Assembly. This legislation requires that all public water supplies in Illinois, regardless of size, be fluoridated by July 1, 1968.

Also during 1967, the Division of Dental Health initiated the use of the self-applied fluoride technic method of getting topical fluorides to children who do not have access to a fluoridated community water supply.

This simple technic involves having children brush their teeth, under supervision, with a prophylaxis paste containing fluorides.

Through its mobile dental clinic, the Division continued to provide a limited amount of dental care to school-age children during the school term and to migrant workers during the summer months.

Food and Drugs

As the result of another new law, the Illinois Food, Drug and Cosmetic Act, which updates the Illinois Uniform Food Act, Illinois residents now receive added protection from the adulteration and misbranding of harmful drugs, cosmetics and devices. The implementation of this legislation by the department's Division of Foods and Drugs will bring about improved federal-state co-operation in a vital health area.

Health Care Facilities and Chronic Illness

The department's Division of Hospitals and Chronic Illness was reorganized during the past year to assist in developing and to make available to all citizens an orderly continuity of care system.

The division now has two major bureaus; the Bureau of Chronic Illness and the Bureau of Health Facilities.

The Bureau of Chronic Illness contains the Section of Adult Health and Chronic Illness and the Nutrition Section. The first administers the Rheumatic Fever, Heart, Cancer, Renal Dialysis, Diabetes and Glaucoma programs, while the second provides consultation in the field of nutrition for the division and the department.

The establishment of the new Chronic Renal Disease Program in the division will provide help to Illinois residents who suffer serious chronic renal failure. The 75th General Assembly appropriated

\$1,000,000 for two years to implement the program. This relatively new medical service is complex and costly, averaging about \$15,000 a year per patient.

The Bureau of Health Facilities is composed of four sections; the Licensure and Medicare Certification Section, the Rehabilitation Section, the Planning and Construction Section and the Consultative and Analytical Services Section.

The Licensure and Medicare Certification Section administers the state licensing program for hospitals and long-term care facilities as well as the Medicare certification program for hospitals, extended care facilities, independent laboratories and home health agencies.

The Rehabilitation Section plans, directs and implements the Rehabilitation Education Service program throughout the state. In addition, this section maintains responsibility for the Rehabilitation Evaluation Committee in the appraisal of long-term care facilities for additional reimbursement by the Department of Public Aid.

The Planning and Construction Section administers the Hill-Burton program and the Packaged Disaster Hospital program.

The Consultative and Analytical Services Section is concerned with providing professional expertise to the department in medical specialties and other scientific fields and, in addition, is responsible for the compilation of vital data for the preparation of cost studies, maternity activities and gynecological studies.

Health Planning and Resource Development

The activities of the department's Division of Health Planning and Resource Development, created in February, 1967, have been directed toward the formulation of plans, policies and procedures for implementation of P.L. 89-749 and its amendments contained in P.L. 90-174 as well as the encouragement of local communities to organize for planning which can lead to the solution of particular local health problems.

This new concept of planning in conjunction with all health related agencies, organizations and groups can correctly be referred to as a Partnership in Health, which should result in more efficient and more adequate attention to health problems in Illinois.

Efforts are also being made to form an Advisory Council for Planning, a Division staff and delineate responsibilities for implementing recommendations for meeting the various health needs.

Local Health Services

The General Assembly passed and Governor Kerner approved legislation authorizing local district health departments and the Peoria City Health Department to increase their tax levy for health programs. Although the increase was not large, from .05% to .075%, it represented an increase which will help these health departments meet their program needs. Also, for the first time in a number of years, the department was given a small increase in budget to financially assist local health departments.

The Division of Local Health Services carries out the general administrative responsibilities for regional offices of the department. It is through these regional offices, the department implements not only its state-wide responsibilities imposed by statute, but also the programs, services and activities inherent in the broad field of public health.

In addition, the administration of the grant-in-aid program through which the federal and state marching funds are allocated to local health departments is a primary concern of this division as is providing assistance to local health departments in recruiting and employing health department personnel who are professionally qualified to carry out public health services.

Milk Control

Early in 1967, the responsibility for administering laws and regulations pertaining to dairy product manufacturing plants was transferred to this division from the Division of Food and Drugs. This eliminated duplicate inspection of many dairy plants processing Grade A fluid milk and milk products and manufacturing ice cream, cheese, butter and other dairy products.

At the present time, rules and regulations to cover all Illinois dairy plants as provided for under the new Illinois Food, Drug and Cosmetic Act, are being prepared by the division. These rules and regulations will be extensions of the federal laws and the Food and Drug Administration.

Preventive Medicine

The department's PKU program moved into its third year of operation with the implementation of an improved system of follow-up on questionable screening test results in co-operation with the Illinois Division of Service for Crippled Children. A pilot screening program for metabolic errors in a high-risk group has been carried out and other programs are planned.

Another goal of Division of Preventive Medicine is to ensure that every child is screened for hearing defects at least once during his elementary education, preferably during the first grade. The department hopes that the age at which this service can be provided can soon be reduced to identify children with a hearing impairment before they enter school.

Training is available to persons with at least a high school education who are working in a hearing conservation program or who have a commitment to be so employed. This includes persons employed by industry and by physicians in private practice.

The Division of Preventive Medicine supports three major services in the area of hearing conservation, audiometric screening and otologic-diagnostic clinics and training. Screening, which includes both audiometric tests and otologic examinations, is provided through local health departments.

Services are also provided through the division to migrant agricultural workers. These include limited hospital and out-patient care, pre and post-natal care, pediatric care including hospital and out-patient services when required, medical care by a physician, public health nursing, dental treatment, immunizations, vision and hearing screening and tuberculin testing in two areas of the state. Nursing services are provided in 16 areas.

Sanitary Engineering

Surface water quality standards were revised to meet requests of the U. S. Department of Interior. Four sets of standards were prepared for approval by the Secretary of Interior in January, 1968. These included standards for Lake Michigan, the Chicago and Calumet River Systems, the Illinois River and

the Rock, Fox, DesPlaines and Kankakee Rivers. Negotiations are still underway regarding final adjustments to the standards for the Wabash, Ohio and Mississippi Rivers.

During the past year, 10 municipalities and 12 industries were cited by the Sanitary Water Board and referred to the Attorney General for legal action. In addition, 12 formal hearings were authorized and four orders to abate pollution were issued. Monetary damages were collected for six instances of pollution-caused fish kills.

There are now 7,897 radiological installations registered with the Division of Sanitary Engineering. These include 1,352 physicians, 4,580 dentists, 503 chiropractors, 370 industries and 318 hospitals. Among other sources of radiation at these installations are 10,600 x-ray machines of all types.

Under the Radiation Monitoring Act, the department receives radiation exposure information on approximately 2,925 persons quarterly. A spot check of the information on the registry reveals that the arithmetic average quarterly exposure is 183,150 and 122 millirems for industrial workers, physicians and hospital employees respectively.

Seven commercial film badge services meeting the minimum performance standards have been approved by the Division.

The department has accepted title to 20.4 acres of land in Bureau County to be used for burial of radioactive wastes. California Nuclear, Inc., is operating the site for the State of Illinois.

A nuclear power station is under construction near Cordova and two units are presently being added at Dresden. Plans for the construction of a nuclear power plant at Zion are also underway.

Plans are also being reviewed for construction of a fuel rod reprocessing plant directly south of the Dresden Nuclear Power site.

Tuberculosis Control

The department through the Division of Tuberculosis Control has continued efforts to promote hospitalization of all active cases of tuberculosis; secure the treatment of non-hospitalized cases; insure the examination of contacts and suspects; provide for tuberculin testing of school children in grades one, five and nine and school personnel; documentation and examination of household associates of reactors in grades one and the encouragement of those infected to take chemotherapy in the form of INH for one year.

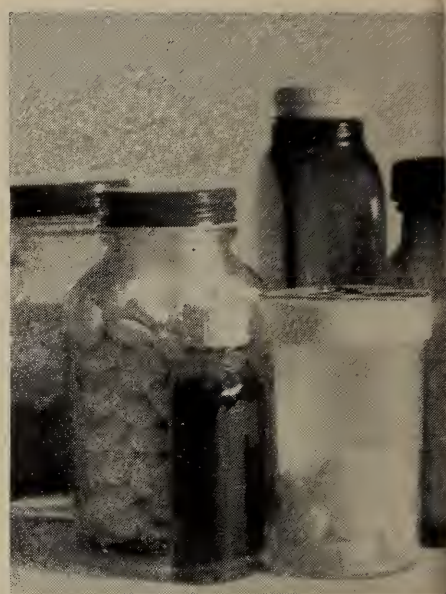
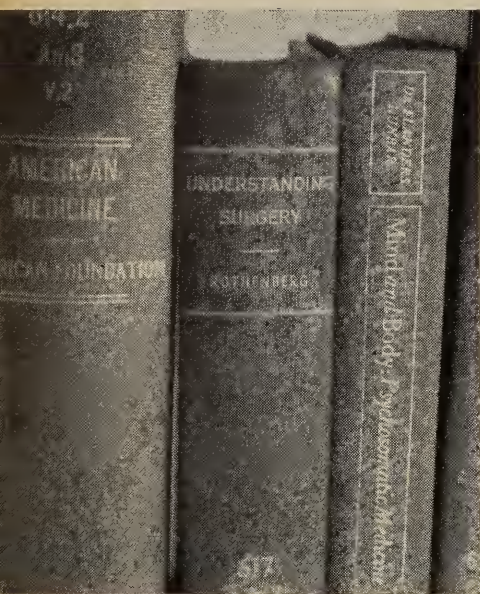
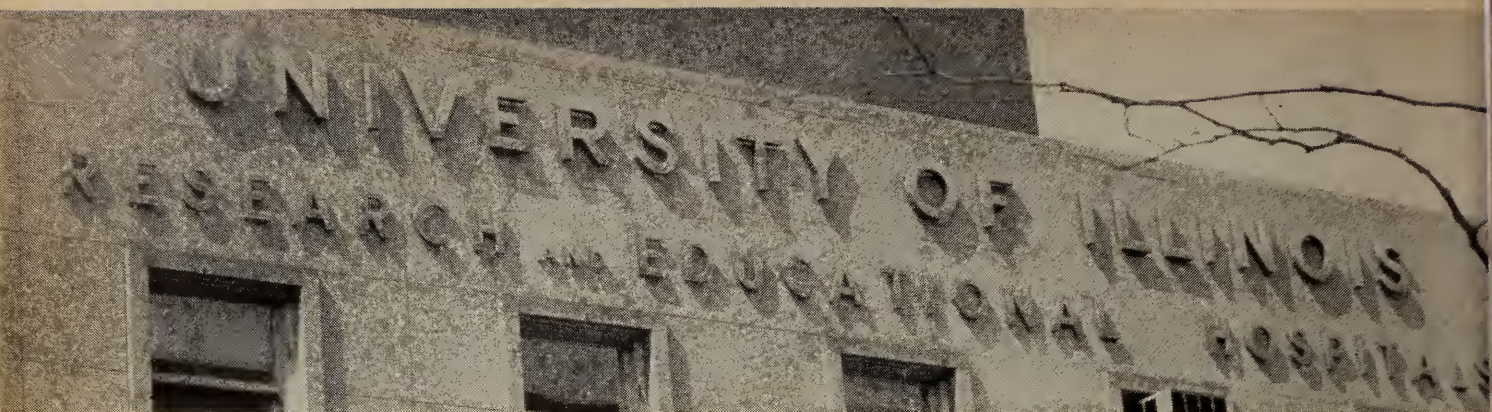
Vital Statistics

Completely revised certificates for recording live births, fetal deaths, deaths, marriages and divorces were introduced by the Bureau of Vital Statistics and became effective Jan. 1, 1968.

The new forms are designed to meet the increasing demands for legal and statistical information and to conform more closely to the U. S. Standard Certificates recommended for nationwide use by the U. S. Department of Health, Education and Welfare's National Center for Vital Statistics.

The State Office of Vital Statistics issued special handbooks to accompany the certificates for hospitals on births and fetal death registration and for funeral directors on death and fetal death registration. Plans were made for a Physicians' Handbook on Medical Certification: Death, Fetal Death and Birth.

Franklin D. Yoder, *Director*



Council on Medical Education

The Council on Medical Education is composed of the committees on Medical Education, Continuing Education, the Rural Health and Student Loan Fund, and Scientific Assembly. The goals of this council are to influence those aspects of the medical education process which have an impact on the practice of medicine and the provision of health care to the people of the state. We foresee the society's role in continuing education as one of providing direction, co-ordination of effort and dissemination of information. We hope that it can be responsible for pinpointing the areas of real need in continuing educa-

tion as they relate to the provision of good health care and guiding the programs of continuing education in the direction of these needs. By bringing together the chairmen of these various committees at Council meetings it is hoped that we may continue to co-ordinate the various medical education activities and at the same time conserve society resources.

Jack L. Gibbs, *Chairman*

Robert T. Fox
Robert J. Freeark

Coye C. Mason
Morgan M. Meyer

COMMITTEE ON MEDICAL EDUCATION

The Committee on Medical Education, which will have met four times between meetings of the 1967 and 1968 House of Delegates, has established excellent rapport with the medical schools of Illinois during the year. Representatives of each of the schools have been present for all meetings of the committee and on no occasion has there been an unresolved difference of opinion between the regular members of the committee and the medical school representatives.

Early in the year the committee concerned itself with restoration of the \$2 dues deduction which was diverted to the Health Careers Council in 1967-1968. At its January meeting, the committee asked Dr. Allison Burdick, Jr., Chairman of the

ISMS Advisory Committee to the HCCI, to report on the council's activities and budget. Following his report, the committee unanimously adopted the following recommendation:

We recognize that we have an obligation in both areas, but we are limited in what we can give to medical schools and recommend that another source be found to provide financial support for the Health Careers Council of Illinois.

The committee is concerned about increasing the number of physicians in Illinois and has studied the enrollment plans of the state's five medical schools. Because of the high cost and length of time needed to build new medical schools,

the committee unanimously adopted the following recommendation:

The Committee on Medical Education strongly concurs with the University of Illinois' proposed expansion plans endorsed by its Board of Trustees on October 16, 1967, and specified in President Henry's Report to the Faculty, dated October 27, 1967. These plans include doubling the size of the University of Illinois medical school in increments by 1971. This would be sooner than any other new school could be formed.

In an effort to sustain private medical schools in the face of rising costs and to avoid as much as possible seeking any more federal money, the committee unanimously adopted the following recommendation:

The Committee on Medical Education recommends that a subsidy be given all medical schools in our state on a per student basis and that the full weight of the state medical society be utilized for this end.

In reply to a request for an accounting of the 1967 AMA-ERF grants, the medical schools replied as follows:

Northwestern University

I wish to report on the disposition of the AMA-ERF funds received by our Medical School through contributions of the membership of the Illinois State Medical Society. From the very beginning of the contributions through the Society I have used the funds as an integral part of the base budget of the Medical School in the support of faculty salaries—indicating that the use was primarily for the salaries of basic scientists. I believe that this policy was wise as the funds should not be specifically designated for a particular faculty member. I have counted on the funds in support of my annual budget.

The figures early in the history of the AMA-ERF (1962) received by Northwestern were in the neighborhood of \$70,000. This has come down regularly each year. For the past few years, while direct alumni giving has increased the amount of money received from the AMA-ERF has decreased and rather precipitously since the 'R-research' was added to the AMA-ERF. At the time of making up my annual budget listing income for the support of my basic budget I always have counted on the AMA-ERF funds in the same way that I count on direct alumni contributions. Last year we received some \$33,000 and when making up my budget for the year 1968-69 I anticipated some reduction in the amount of contribution and, therefore, put in as anticipated income for the 1968-69 academic year \$30,000 from the ISM. It is with dismay that I note the income for the year 1967 dropped to a little over \$21,000.

The withdrawal of \$2.00 from the member allocation was very arbitrary and contrary to the spirit of the individual gift.

As the funds have dropped so precipitously and competition for faculty positions has been so severe \$21,000 would barely support an assistant professor in the Department of Anatomy.

A great many of the privately endowed schools in the United States are desperately short of funds, and it is unfortunate that during these critical

times the support of the Medical Society is being curtailed.

Sincerely yours,
Richard H. Young, M.D., Dean

University of Illinois

I am pleased to respond to your letter of February 27, 1968 requesting information regarding the use of AMA-ERF funds since Dean Bennett reported to you on February 14, 1967 for the period ending July 1, 1966.

As has previously been the case, AMA-ERF funds are maintained in a separate account by the University and are used only for purposes which the faculty and administration of the College of Medicine consider important. This year the report will cover the period July 1, 1966 to January 1, 1968. During the period one assistant professor of anesthesiology was supported at seventy per cent time and one clinical associate professor of surgery was supported at twenty per cent time. Both of these individuals contributed heavily to the teaching and patient care activities.

A modest amount of money was used to conduct an evaluation of the clinical curriculum. For many years an argument has been raging in medical education over whether it is better to provide a massed outpatient experience for the medical student or whether an outpatient experience extended over many months or years provides the better setting for learning. A curriculum change undertaken by the faculty provided an opportunity to seek a resolution to the arguments.

A small amount of AMA-ERF funds have been used to enhance special programs that could not otherwise have been undertaken. For example, it seemed appropriate that Doctor Bennett provide all of the alumni of the College with information concerning his retirement and the progress made in the College under his administration. A very modest amount of funds was used to support this project.

With his usual foresight Doctor Bennett conserved these funds after he made the decision to retire in order to provide the incoming dean with a ready source of funds. He was aware that within a short period of time, three department heads would be replaced due to retirement. AMA-ERF funds are particularly useful to support the projects and additional personnel that inevitably are required when new department heads take over. As the new Dean, I can assure you that I am very pleased that a relatively large balance remains in this account but I can assure you that these funds and any others that become available will be put to work immediately.

We are most appreciative of the help that this resource has been able to provide.

Sincerely yours,
William J. Grove, M.D., Dean

The Chicago Medical School

I am responding to your letter of February 27 relative to the AMA-ERF funds that were allocated to The Chicago Medical School. We received in April, 1967 the sum of \$26,540.93. As always these funds have been most useful to us in our educational research programs. More specifically, they have been carefully allocated in

amounts ranging from \$3,000 to \$5,000 for partial support of the salaries of the following full-time faculty.

- (1) Assistant Professor in Obstetrics & Gynecology
- (2) Associate in Psychiatry
- (3) Associate in Pediatrics
- (4) Two Assistants in Medicine
- (5) Visiting Professor in Ophthalmology

The remaining approximately \$2,000 have been utilized to support five student projects both here at the Medical School as well as on elective research and clinical programs elsewhere.

It is increasingly clear how vital and significant these funds are to us. These unrestricted amounts permit appropriate flexibility in both maintaining and beginning new areas involved in medical education especially in teaching. Each year they become more important because of the limits and restrictions that are gradually being placed on other amounts.

In behalf of our institution I want to express our deep appreciation for your dedication and generosity.

Sincerely,

Le Roy P. Levitt, M.D., Dean

Loyola University

The following is a breakdown of the allocation of the AMA-ERF funds which were received by this School. The funds were used to provide full salary for an assistant professor of pharmacology and the remainder for part of the salary of an assistant professor of physiology.

John F. Sheehan, M.D.

Vice President for the Medical Center & Dean,
Loyola University Stritch School of Medicine

University of Chicago

Dean Jacobson has asked me to answer your letter concerning our use of AMA-ERF funds. These funds, needless to say, have been most useful to us as we pursue our efforts to improve our Medical School and to produce physicians who will be the leaders of the future. This year we have used the AMA-ERF funds for salary support—an area which is most intensely needed during this period of hard financial times for all universities. This year we directed our attention to several areas in our educational program which seemed to warrant particular emphasis.

First, it was very apparent that it was urgent to do something about the Section of Orthopedic Surgery at this University. The last chief of that Section had resigned early in 1966 and the Section was left with a relatively small group of individuals who were responsible for the teaching and service in that area. I am happy to report that as a result of the support which we were able to receive from the AMA-ERF fund that we were able to recruit Dr. Jack Stevens, who is the current head of that Section. We felt particularly fortunate in finding Dr. Stevens since his reputation is an excellent one and his ability in the field of orthopedic surgery is truly outstanding. Prior to his coming to the University of Chicago, he was Chairman of the Department of Orthopedic Surgery at Cook County Hospital. Dr. Stevens came to this country from

England, where he received his undergraduate education at Cambridge University and finished his clinical education at the University College Hospital Medical School in London. From 1959 to 1965 he was on the faculty at the University of Glasgow and in the latter year he came to the Cook County Hospital as was mentioned above. He is the co-author of many papers and we look forward to outstanding leadership in this area of our program.

Another individual who came to the faculty this year was Dr. Daniel J. McCarty. Dr. McCarty came to this institution from the Hahnemann Medical College to head up the Section of Arthritis in the Department of Medicine. Dr. McCarty is a member of many professional societies and is currently editor of *Arthritis and Rheumatism* which, as you know, is the official journal of the American Rheumatism Association. He has many honors and is the author of many papers and has written chapters in several textbooks. It is interesting that these two men, Drs. Stevens and McCarty, are particularly interested in working together in the field of rehabilitation and we expect that the two working together will be able to materially improve this part of our educational program here at the University of Chicago.

In addition to these two outstanding appointments, I could name two others. One is that of Dr. Harvey Zarem, who has had a particular interest in plastic surgery. This is a Section at this University which has not received great stress in the past but has now, we feel, begun to emerge as a strong Section in the Department. I should mention perhaps that Dr. Zarem comes to us from Johns Hopkins Hospital where he completed his training in plastic surgery.

A final individual whom I would like to mention is Dr. Arnold M. Katz. Dr. Katz came to the University of Chicago from Columbia University where he was in the Department of Physiology and also an assistant physician on the medical service at the Presbyterian Hospital. Dr. Katz joins the Section of Cardiology in the Department of Medicine where he is particularly interested in relating clinical medicine to the work which he has done in the past in physiology.

These four appointments to our medical staff have been significant ones in the past year, and we look upon them as real additions to our teaching efforts. We are happy at this time to acknowledge the assistance which has been given to their recruitment through the AMA-ERF fund. If you wish further information concerning the use of this money, please do not hesitate to write.

Sincerely yours,

Robert G. Page, M.D., Associate Dean

Morgan M. Meyer, *Chairman*

Hershel Browns	Peter V. Moulder
Leonard D. Grayson	F. H. Riordan III
William F. Hubble	James Sours
Jerry Ingalls	James A. Weatherly

MEDICAL SCHOOL REPRESENTATIVES

LeRoy Levitt, *Chicago Medical School*
Adrian M. Ostfeld, *University of Illinois*
Robert G. Page, *University of Chicago*
Edward S. Peterson, *Northwestern University*
William Barrett Rich, *Loyola University*

CONSULTANTS

William M. Lees	Caesar Portes
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COMMITTEE ON CONTINUING EDUCATION

The Committee on Continuing Education remains concerned about the general lack of co-ordination of postgraduate education throughout the State of Illinois. It notes that various courses and programs are being prepared by medical schools, hospitals, medical societies and other organizations with considerable reduplication of effort and uncertain results. It further notes that the actual educational needs of Illinois physicians are not being met uniformly and that a recent survey of physician attitudes suggested that the practicing doctors look to their State Medical Society to meet their educational needs.

With the advent of the Illinois Regional Medical Program for Heart Disease, Cancer, Stroke and Allied Diseases, there is a growing need to evaluate existing programs and plan for the future. In conjunction with the annual meeting of the society, the committee will sponsor a workshop for hospital directors of medical education, medical chiefs of staff, and other physician representatives of the many hospitals throughout the State. The committee views the hospital as the primary education center and will attempt through this workshop, to evaluate both the depth and extent of the continuing education requirements of the practicing physician. Later, the committee hopes to translate its findings into specific recommendations for co-ordinating all postgraduate education in the state. The committee takes the position that continuing education of physicians is an integral part of any program connected with improving medical care—the basic purpose of the Illinois State Medical Society.

The committee further recognizes that, at present, it is not able to provide educational programming for all areas in the state. It is able to assist in many ways those who would do their own programming. It wishes to encourage county medical societies to use its Speakers' Bureau Roster, which is up-to-date with a wide variety of subjects and interesting speakers. Merck, Sharp and Dohme, which has been supporting this program for several years, has provided another \$5,000 to pay expenses and honoraria for speakers participating in county medical society programs during 1968, and the committee urges the societies to utilize the service.

Robert J. Freeark, *Chairman*

Hubert Allen	John L. Kelley
W. W. Bowers	Louis P. Limarzi
T. Howard Clarke	Edward S. Petersen
Louis N. Katz	Gordon H. Sprague

William R. Thompson

William E. Adams, *Consultant*

RURAL HEALTH AND MEDICAL STUDENT LOAN FUND COMMITTEE

Interview Meeting in Bloomington

On Jan. 24 and 25, 1968, the Joint ISMS/IAA Committee met in Bloomington at the IAA offices for a business and interview meeting. It was agreed that the committee would arrange for distribution of informational pamphlets and a letter noting the availability of the loan portion of the program to students at other medical schools in Illinois and out-of-state.

The committee will contact the pre-medical advisors in undergraduate colleges in the midwest area regarding the availability of the program to present and future medical students that are permanent residents of Illinois.

Student applicants were interviewed on the 25th of January. Seven of the board's 10 recommendations were later accepted for the freshman class of 1968 by the University of Illinois Committee on Admissions. Unfortunately, the Admissions Committee "concluded that the credentials and qualifications" of the remaining three Board recommendations "were not predictive of success in medical studies and voted to deny their applications."

Loan Fund Financial Status

The total value of the Student Loan Fund at Jan. 08, 1968, was \$229,889 (owned 50/50 by ISMS and the Illinois Agricultural Association). The assets of the fund at that date, compared with one year ago, were:

1/08/68		12/07/66
\$ 75,000	U.S. Treasury bills	\$ 82,000
131,505	2% Student Promissory Notes	131,780
16,834	Cash	4,475
6,550	Liquidating penalties due	-0-
<u>\$229,889</u>		<u>\$218,255</u>

The fund received 2 per cent interest income in 1967 amounting to \$3,601 (\$4,057 in 1966); \$5,190 was received from investment in short-term U.S. Treasury bills (\$1,893 in 1966). The only expense of the fund in 1967 was \$1,360 for bank trust department administration fees (\$1,320 in 1966). A trust fund surplus of \$7,431 resulted for the current year.

Annual Students' Dinner

On Nov. 3, 1967, the committee hosted its present medical school students and their wives at the annual dinner meeting. Philip G. Thomsen, M.D., ISMS president-elect and University of Illinois Medical School Dean Granville A. Bennett, M.D., addressed the gathering of students and medical school, medical society, and agricultural association officials. Dr. Thomsen discussed the "Physician Shortage and You" with the medical students and wives, noting that "first and foremost, the need is for doctors who will go out into the communities where there are no physicians . . . who will be concerned with total patient care . . . in short, who will be the *primary physician* who takes charge of a family's total health situation." There could be no more apt description of our committee's goals than was expressed in these words.

The meeting was held for the first time at the university's new Union Building, and the appearance and facilities were given unanimous acclaim by all. Leon Silin, Assistant Regional Representative from the Bureau of Health Insurance, Department of HEW, was present to lead a discussion regarding Medicare's effect on medical education. A film prepared by the Social Security Administration, with the assistance of the Student American Medical Association, especially for medical students was viewed. A forthright discussion of changes in medical practice caused by government direction and controls closed a most enjoyable and worthwhile evening.

Emergency Medical Services in Rural Areas

The American Medical Association's Council on Rural Health has been pursuing implementation of a five-point program for improving emergency medical services in rural areas.

The program is the first step in a larger AMA project to insure excellence of emergency services nationwide. Particular emphasis is laid upon wider first aid training for rural Americans and swifter handling of emergency victims.

A study of rural and urban traffic fatalities in California showed one and one-half times as many people injured per 1,000 population in traffic accidents in rural counties (under 50,000 population) as contrasted with urban counties (over 500,000 population) and that people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries.

The higher case fatality ratio in rural areas seemed to be related to the inability to provide adequate first aid procedures and to get the person to a hospital within a reasonable period of time.

Our committee is considering the possibility of leading a program of advance Red Cross first aid instruction in rural communities for the non-medical people most frequently called in rural emergencies—police, sheriffs, and ambulance crews. A long-term goal is to have at least one member in every rural family trained in first aid procedures. The already-established ISMS TV film series on Disaster Medical Care could be a useful teaching aid in this effort.

Co-operation with ISMS Legislative Committee

In conjunction with the present-day problem of obtaining admission to the University of Illinois College of Medicine for students with a desire to practice in downstate areas, the Rural Health Committee has begun a program with the ISMS Legislative Committee to obtain additional support from the Illinois Legislature regarding the merits of our program. Since the medical school at the Chicago campus is hoping to double the number of incoming freshmen that can be accepted, and with the anticipated building of a downstate medical school, it is anticipated that additional spaces can be set aside in each year's freshman class for participants in the ISMS/IAA Loan Fund program—if the qualified applicant pool is increased enough to warrant this.

Plans now underway, and mentioned earlier above, to present information about the program to the faculty advisers of students interested in practice in a rural area and who need financial assistance should help to enlarge the number of undergraduates that want to participate in the program. We can justifiably expect to receive additional spaces in each year's freshman class only by offering the University of Illinois Medical College a greater number of students that are fully-qualified to compete in the regular selection competition. Legislative resolution encouraging admission of students that have indicated the desire to practice in rural areas will be urged at the next session of the General Assembly.

The current policy for medical schools to accept only the "All A's" student and then work downwards is just not compatible with the need for training more generalists for practice locations in the downstate physician-needy areas.

Medical students from Illinois in out-of-state schools are qualified to receive financial assistance under this program, as long as they are willing to agree to practice in a rural area for at least five years

following completion of training. Physicians and county medical societies that know of medical students that need financial aid and who would be interested in establishing their practice in a non-metropolitan area are asked to get in touch with the ISMS office for further details.

Jack Gibbs, *Chairman*
Charles Salesman Donald L. Stehr
Jacob E. Reisch, *Consultant*

COMMITTEE ON SCIENTIFIC ASSEMBLY

The Committee on Scientific Assembly held its planning meeting for the 1968 Convention on Nov. 8, 1967.

All sections that have traditionally participated in the convention were present, except for anesthesiology, which declined this year's invitation.

In addition, the Director of Exhibits took his place as a regular member of the committee, the Committee on Scientific Exhibits having been eliminated in the reorganization of the society's committee system.

During the year, Dr. Mason, who has served as Director of Exhibits for a number of years asked the Board of Trustees to appoint Dr. J. Robert Thompson, as his assistant, with a view to turning over the assignment to Dr. Thompson next year. This appointment was approved by the Board.

Word has been received from the Mead Johnson Co. that this will be the last year that its Aesculapius Award will be made for the best scientific exhibit at our convention. The Committee on Scientific Assembly is appreciative of the contribution made by Mead Johnson in 1966, 1967 and 1968 in presenting this award.

Robert T. Fox, *Chairman*
Coye C. Mason, *Director of Exhibits*

John J. Brosnan Charles P. McCartney
Robert R. Fahringer Harold P. McGinnes
Robert G. Page J. Robert Thompson
Donald L. Unger
William M. Lees, *Consultant*

AUXILIARY REPRESENTATIVES

Mr. H. C. Schorr Mrs. Bruno Beinoris

SCIENTIFIC SECTION CHAIRMAN

Allergy—Arnold A. Gutman
Dermatology—Marshall L. Blankenship
E.E.N.T.—E. Skolnick
Internal Medicine—Angelo P. Creticos
Neurology & Psychiatry—Harold M. Himwich
Obstetrics & Gynecology—Thomas R. Wilson
Pathology—Gerald Dean
Pediatrics—Ira M. Rosenthal
Physical Medicine & Rehabilitation—W.T. Liberson
Preventive Medicine & Public Health—Fred Long
Radiology—J. Homer Goodlad
Surgery—Burton C. Kilbourne

Resolutions

RESOLUTION 68M-1

Introduced by: Kane County Medical Society
Subject: ACCOUNTING TO HOUSE OF DELEGATES
FOR USE OF AMA-ERF FUNDS
Referred to: Reference Committee on Publications & Scientific Services

WHEREAS, The incorporation of AMA-ERF contributions into the dues structure of the Illinois State Medical Society was approved by the House of Delegates, and

WHEREAS, Annual accounting of this fund as to its use and purpose is appropriate, and

WHEREAS, Such detailed accounting was requested by the House of Delegates at the 1966 Annual Meeting, and

WHEREAS, The promised accounting was not forthcoming at the 1967 Annual Meeting so that the delegates could determine that AMA-ERF funds used conformed to the intentions of the members, now, therefore be it

RESOLVED, That AMA-ERF be removed from the mandatory dues collection system of the Illinois State Medical Society

RESOLUTION 68M-2

Introduced by: Kane County Medical Society
Subject: LEGISLATION RE TRANSFUSING OF
WHOLE BLOOD OR BLOOD PRODUCTS
OR THE TRANSPLANTATION OF HUMAN
TISSUES AS A MEDICAL SERVICE
Referred to: Reference Committee on Legislation & Public Affairs

WHEREAS, The use of whole blood and the various fractions thereof for transfusion and the use of human tissue for the transplantation to another who will medically benefit from such a transfusion or transplantation are a part of good medical practice, and

WHEREAS, The Federal Trade Commission has taken upon itself the authority to hold blood to be a commodity subject to the laws of implied warranty, and

WHEREAS, The Supreme Court of the State of Florida has recently ruled that this doctrine of implied warranty is applicable even though it acknowledged that there is no known test for the detection of the virus of serum hepatitis, and

WHEREAS, These actions by non-medical governmental bodies now pose a serious problem and threat to the public health and welfare and to blood banking and the procurement of blood products in particular for medical use, and

WHEREAS, Several states have already enacted legislation to negate the mischievous actions of these non-medical bodies for the protection of their citizens, therefore be it

RESOLVED, That the Illinois State Medical Society, through its legislative committee, assist in the formulation and the passage through the Illinois State Legislature, legislation to effect that

1. The procurement, processing, distribution or use of whole blood, plasma, blood products, blood derivatives, and other human tissues such as corneas, bones, or organs for the purpose of injecting, transfusing, or transplanting any of

them into the human body for any purpose whatsoever, where there is no medical test to determine the fitness of such whole blood plasma, blood products, blood derivatives or other human tissues, shall be deemed the rendering of a service and not to constitute a sale by any person participating therein, whether or not remuneration is paid therefore, and that

2. the provisions of the uniform commercial code be amended to provide that the implied warranties of merchantability and fitness shall not be applicable to a contract for the sale of human blood, plasma, blood products, blood derivatives, or other human tissues or organs from a blood bank or reservoir of such other tissues or organs.

RESOLUTION 68M-3

Introduced by: DuPage County Medical Society
Subject: ENLARGEMENT OF A JUNIOR-SENIOR
MEDICAL PRECEPTORSHIP PROGRAM
Referred to: Reference Committee on Publications & Scientific Services

WHEREAS, DuPage County is concerned with the need for more practical experience in present day medical education and

WHEREAS, The DuPage County Medical Society program for senior medical preceptorships has been received enthusiastically both by the students and by the Chicago Medical School, and

WHEREAS, the chairman of the ISMS Committee on Medical Education has contacted the counties surrounding the Chicago area concerning the enlargement of this State Society sponsored preceptorship program to include these counties, now therefore be it

RESOLVED, That the Illinois State Medical Society exert every effort to enlarge the junior-senior medical preceptorship program, and attempt to secure the necessary financing to insure the success of a meaningful, ongoing preceptorship program available to all Illinois medical schools, and be it further

RESOLVED, That representatives of the Illinois State Medical Society consult with all medical schools in the state to explore methods for expanding this program and supervising its development and progress.

RESOLUTION 68M-4

Introduced by: DuPage County Medical Society
Subject: MEDICALLY ORIENTED SUMMER JOB
PROGRAM FOR FRESHMAN MEDICAL
STUDENTS

Referred to: Reference Committee on Publications & Scientific Services

WHEREAS, The Student AMA, University of Illinois chapter, has requested the Illinois State Medical Society to help formulate a program of medically oriented summer jobs, and

WHEREAS, The chairman of the ISMS Medical Education Committee has requested the DuPage County Medical Society to help formulate a program of medically related summer jobs, and

WHEREAS, Our county society has repeatedly deplored the lack of practical experience in the present day medical education system, and

WHEREAS, The DuPage County Medical Society pilot program of medical preceptorship has been enthusiastically received both by the students and by the Chicago Medical School, therefore be it

RESOLVED, That the ISMS go on record as supporting all of the local county medical societies throughout the state in their efforts to make available summer jobs for medical students, in medically related laboratories, hospitals and medical doctors' offices.

RESOLUTION 68M-5

Introduced by: Jackson County Medical Society
Subject: LEGISLATION TO AMEND THE HOSPITAL LICENSURE ACT
Referred to: Reference Committee on Legislation and Public Affairs

WHEREAS, Every hospital which has a surgery department is required to maintain and man an emergency room with the active staff of the hospital on nightly call duty, and

WHEREAS, The maintaining of such an emergency room in cities of 50,000 population or under having two or more hospitals, is a waste of medical resources and manpower, and

WHEREAS, It is not possible under the present law to combine staffs and emergency rooms in smaller communities, therefore be it

RESOLVED, That the Illinois State Medical Society be directed to proceed with the initiation of legislation amending the Hospital Licensure Act to permit the consolidation of staffs and emergency rooms and to permit the operation of only one emergency room with physicians on call in cities with less than 50,000 population and with two or more hospitals.

RESOLUTION 68M-6

Introduced by: Madison County Medical Society
Subject: LEGISLATION RE PHYSICAL EXAMINATION OF PRE-SCHOOL CHILDREN
Referred to: Reference Committee on Legislation and Public Affairs

WHEREAS, We believe that early diagnosis and early planning is essential in the management of handicapped children, and

WHEREAS, The Illinois School Code was amended in 1965 to provide for the earlier rehabilitation of handicapped children starting at age 3, and

WHEREAS, School registration when a child reaches his 3rd birthday could establish a network of co-operative communications between the parent, the private physician and the school authorities to check on the absence of handicaps, general status of physical and mental health, immunization program and availability of classroom facilities, now therefore be it

RESOLVED, That the ISMS advise the Illinois School Problems Commission of the Board of Education of the State of Illinois, to request the legislature of the State of Illinois to amend the school code section 27-8 to read:

"Medical examinations of the initial school registration for kindergarten or first grade in school shall be given whenever possible within 30 days of the THIRD birthday, as well as within 30 days prior to the start of the school year".

RESOLUTION 68M-7

Introduced by: Kane County Medical Society
Subject: TERM OF OFFICE OF AMA DELEGATES
Referred to:

WHEREAS, The House of Delegates of the Illinois State Medical Society meeting in annual convention in May 1967 did amend its constitution to provide that "No member of a council shall serve more than three consecutive terms", and

WHEREAS, The Opinion Research Corporation in its *"An Appraisal of the Illinois State Medical Society by its Membership"* did recommend that the State Medical Society could benefit from more emphasis on the young physician, and

WHEREAS, This same survey did report that the membership of the Society did "score" organized medicine for failing to be "socially and politically responsive" and "for acting only after the fact", and

WHEREAS, Earlier studies have shown that the interest and effectiveness of a member in the affairs of the Society tend to rise in a predictable pattern and then decline, therefore be it

RESOLVED, That the Illinois State Medical Society extend the rules governing membership on councils to its AMA Delegates, that no AMA Delegate may serve more than three consecutive terms, and be it further

RESOLVED, That this provision may be waived for a Delegate to the AMA by this House of Delegates for one term if that AMA Delegate is a chairman of an AMA Council.

RESOLUTION 68M-8

Introduced by: Vermilion County Medical Society
Subject: LEGISLATION REGARDING THE PRACTICE OF MEDICINE WITHOUT A LICENSE
Referred to: Reference Committee on Legislation and Public Affairs

WHEREAS, There are persons in the state of Illinois practicing systems of healing the sick, and diagnosing and treating mental and physical conditions without having a certificate under the Medical Practice Act; and

WHEREAS, Such practices create a risk of great bodily harm, serious mental or physical illness, or death, now therefore be it

RESOLVED, That the Illinois State Medical Society, through its Legislative Council, submit a bill to the Illinois State Legislature making it a felony rather than a misdemeanor to commit such an act.

NOTE: The Vermilion County report enclosed a recent amendment approved in California along these lines for the Legislative Council. They also stated in their letter that they understood that Senator Tom Merritt of Hoopston was willing to sponsor and submit such a bill if the State Medical Society indicates he should do so, and gives support.

RESOLUTION 68M-9

Introduced by: DuPage County Medical Society
Subject: FUNDS FOR MEDICAL EDUCATION & THE ISMS EDUCATIONAL & SCIENTIFIC FOUNDATION

Referred to: Reference Committee on Publications and Scientific Services

WHEREAS, The Illinois State Medical Society House of Delegates has historically been vitally concerned with medical education within our state, and

WHEREAS, The need for funds for medical schools, schools of nursing, and schools in the para-medical field, and for the procurement of students for these schools, has grown in the past few years, and

WHEREAS, The Health Careers Council placed its urgent plea for funds before the 1967 House of Delegates and succeeded in diverting \$2 from the traditional \$20 per member turned over to AMA-ERF, for a one year period, and

WHEREAS, The ISMS Medical Education Committee has received urgent requests for reinstatement of this full \$20 allocation to the AMA-ERF fund, and

WHEREAS, Allison L. Burdick, Jr., M.D., Chairman of the ISMS Health Careers Council Committee, has met with the Medical Education Committee and agreed that another source for funds for the Health Careers Council should be sought, now therefore be it

RESOLVED, That the ISMS should

- (1) reinstate the full \$20 per member allocation to the AMA-ERF fund for medical schools, and
- (2) make additional effort to raise money not only from ISMS membership, but also from patients, industry, church-related or other groups, for the Illinois State Medical Society Educational and Scientific Foundation to enable the Society to take active and vigorous leadership in the support of various programs in medical education and also in the para-medical fields.

RESOLUTION 68M-10

Introduced by: DuPage County Medical Society

Subject: LEGISLATION FOR PER-STUDENT-SUBSIDY TO MEDICAL SCHOOLS IN ILLINOIS

Referred to: Reference Committee on Legislation and Public Affairs

WHEREAS, The costs of medical education

throughout the country have risen fantastically in the past few years, and

WHEREAS, It was the unanimous opinion of the representatives of all five medical schools in Illinois that the need for funds to all these schools was urgent, and

WHEREAS, The climate for co-operative efforts in medical education in our state has improved considerably in the past few years, as witnessed by the increasing co-operation in the ISMS Medical Education Committee and the institution of the DuPage County Medical Society pilot program of senior preceptorship, and

WHEREAS, There has been widespread interest in the medical profession and the laity to build another medical school in the state of Illinois to help alleviate our critical doctor shortage, and

WHEREAS, The University of Illinois has presently projected plans for doubling the size of their present graduating class to 400 by the early 1970's, and

WHEREAS, The costs of building a new school are much higher than the cost of supporting and enlarging presently operating schools, and

WHEREAS, The time lapse from decision to build and staff a new school until students are actually graduating is usually in excess of ten years, and

WHEREAS, An across-the-board-per-student subsidy has been functioning very advantageously in the state of Pennsylvania for many years with a relatively high retention of the graduating physicians within the state regardless of their originating home state, therefore be it

RESOLVED, That the Illinois State Medical Society shall formally support the concept of a per-student subsidy to all of the medical schools within the state of Illinois; and direct its Legislative Council to take proper action in sponsoring a bill which will authorize an across-the-board-per-student subsidy to all of the medical schools in the state of Illinois.

*For those not attending
Reference Committee meetings*

SUNDAY, MAY 19

A Symposium on Ethical Considerations of Abortion

Co-sponsored by the Illinois
State Medical Society Committee
on Religion and Medicine and the
Catholic Physicians' Guild

7:30 p.m. French Room 107

A Workshop on Continuing Education for Practicing Physicians

Sponsored by the Illinois State
Medical Society Committee on
Continuing Education for hospital
directors of medical education and
others interested in teaching programs
7:30 p.m. Louis XVI Room

“Total Care”

Program Summary

1968 ISMS Convention

Saturday, May 18

- 12:00 noon** Board of Trustees Luncheon
Gold Room 114
- 2:00 p.m.** Board of Trustees Meeting
Crystal Room
- 6:00 p.m.** AMA Delegates Dinner
Ruby Room 113

Sunday, May 19

- 10:00 a.m.** Registration of Officers and Delegates
Parlors M-N-O
- 11:30 a.m.** Reference Committee Chairmen
Luncheon
French Room 107
- 12:30 p.m.** District Meetings (as called)
- 1:00 p.m.** 1968 Conference on Hospital Cancer Programs
Louis XVI Room
- 2:00 p.m.** Credentials Committee, House of Delegates
Executive Ballroom Foyer
- 3:00 p.m.** House of Delegates
Executive Ballroom
- 5:30 p.m.** Delegates Buffet
Louis XVI Room
- 6:00 p.m.** Illinois Obstetrical & Gynecological Society Board Dinner
Gold Coast Room 111
- 7:00 p.m.** Reference Committees:
Officers and Administration
Crystal Room
Finances and Budget
Jade Room 103
Constitution and Bylaws
Holiday Room 105
Economics and Insurance
Old Chicago Room 101
Legislation and Public Affairs
Gold Room 114
Publications and Scientific Services
Parlor L
Public Relations and Miscellaneous Business
Ruby Room 113
- 7:30 p.m.** Workshop on Continuing Education of Practicing Physicians
Executive Ballroom
- 7:30 p.m.** Symposium on Ethical Considerations of Abortion
French Room 107

Monday, May 20

- 8:00 a.m.** Board of Trustees Breakfast
French Room 107
- 8:00 a.m.** Illinois Surgical Society
Cook County Hospital

- 8:30 a.m.** Illinois Obstetrical and Gynecological Society
Crystal Room
- 8:30 a.m.** Registration
Mezzanine
- 9:00 a.m.** Alcoholism Symposium
Gold Room 114
- 9:00 a.m.** Occupational Health
Louis XVI
- 11:00 a.m.** Official Opening of Exhibits
- 12:00 noon** Illinois Obstetrical and Gynecological Society Luncheon
Ruby Room 113
- 1:00 p.m.** Section on Neurology and Psychiatry
Louis XVI Room
- 1:30 p.m.** Section on Surgery and Illinois Surgical Society
Executive Ballroom
- 4:00 p.m.** IMPAC Annual Meeting
Gold Room 114
- 5:00 p.m.** Exhibits Close
- 6:00 p.m.** Public Affairs Dinner and Camp Memorial Lecture
Bal Tabarin
- 6:00 p.m.** Past-President's Dinner

Tuesday, May 21

- 8:00 a.m.** Board of Trustees Breakfast
French Room 107
- 8:30 a.m.** Registration Opens
Mezzanine
- 8:30 a.m.** Section on Allergy
Gold Room 114
- 9:00 a.m.** Section on Obstetrics and Gynecology
Ruby Room 113
- 9:00 a.m.** Exhibits Open
- 9:00 a.m.** Diabetes in Pregnancy and Children
Jade Room 103
- 12:00 noon** Fifty Year Club and Sesquicentennial Luncheon
Louis XVI
- 12:30 p.m.** Illinois Academy of Preventive Medicine Luncheon
French Room 107
- 1:00 p.m.** Continuing Education Program in Psychiatry for Physicians in Private Practice
Jade Room 103
- 1:30 p.m.** Section on Radiology
Crystal Room
- 1:30 p.m.** Section on Physical Medicine and Rehabilitation
Gold Room 114
- 1:30 p.m.** Credentials Committee, House of Delegates
Executive Ballroom Foyer

(Tuesday, May 21—continued)

- 2:00 p.m. House of Delegates
Executive Ballroom
- 2:00 p.m. Section on Public Health and Preventive Medicine
Ruby Room 113
- 5:00 p.m. Exhibits Close
- 6:00 p.m. Illinois Society of Pathologists Dinner
Ruby Room 113
- 6:30 p.m. President's Dinner
Bal Tabarin
- 9:00 p.m. Mexican Fiesta
Grand Ballroom

Wednesday, May 22

- 8:00 a.m. Board of Trustees Breakfast
French Room 107
- 8:30 a.m. Registration Opens
- 8:30 a.m. Section on Eye, Ear, Nose and Throat
Crystal Room
- 8:30 a.m. Section on Pathology
Gold Room 114
- 9:00 a.m. Exhibits Open

- 9:00 a.m. Section on Pediatrics
Louis XVI Room
- 9:00 a.m. Section on Dermatology
Executive Ballroom
- 9:00 a.m. Section on Internal Medicine and Illinois Society of Internal Medicine
Old Chicago Room 101
- 12:30 p.m. Illinois Chapter, American Academy of Pediatrics Luncheon
Gold Room 114
- 12:30 p.m. Illinois Society of Internal Medicine Luncheon
Jade Room 103
- 12:30 p.m. Illinois Academy of General Practice Luncheon
Old Chicago Room 101
- 1:30 p.m. Credentials Committee, House of Delegates
Executive Ballroom Foyer
- 2:00 p.m. House of Delegates
Executive Ballroom
- 2:00 p.m. Peripheral Vascular Diseases
Randolph Room
- 5:00 p.m. Exhibits Close
- 6:00 p.m. Board of Trustees Dinner
Randolph Room

HOUSE OF DELEGATES MEETINGS

Executive Ballroom

Sunday, May 20	3:00 p.m.
Tuesday, May 22	2:00 p.m.
Wednesday, May 23	2:00 p.m.

Reference Committee Meetings

Sunday, May 20	7:00 p.m.
Officers and Administration	Crystal Room
Finances and Budget	Jade Room 103
Constitution and Bylaws	Holiday Room 105
Economics and Insurance	Old Chicago Room 101
Legislation and Public Affairs	Gold Room 114
Publications and Scientific Services	Parlor L
Public Relations and Miscellaneous Business	Ruby Room 113

Board of Trustees Meetings

Saturday, May 19	Noon	Gold Room 114
Saturday, May 19	2:00 p.m.	Crystal Room
Monday, May 20	8:00 a.m.	French Room 107
Tuesday, May 21	8:00 a.m.	French Room 107
Wednesday, May 22	8:00 a.m.	French Room 107
Wednesday, May 22	6:00 p.m.	Randolph Room

Program is acceptable for 24 elective hours by the American Academy of General Practice

Calls Will Reach You Easily at the '68 Convention

Doctor, please inform your staff that while you are attending the ISMS Convention, you may be reached through the Physician's Message Center from 2:00 p.m., to 5 p.m., Sunday, and from 9:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday. Here is the number to remember:

312-236-9560

This is a direct connection which will not go through the hotel switchboard.

Convention Program by Days

WORKSHOP ON CONTINUING EDUCATION OF PRACTICING PHYSICIANS

Sunday, May 19 Executive Ballroom
Chairman: Robert J. Freeark, M.D., ISMS
Committee on Continuing Education
7:30 p.m.

SYMPOSIUM ON ETHICAL CONSIDERATIONS OF ABORTION

Sunday, May 19 French Room 107
7:30 p.m.
Co-sponsored by the Illinois State Medical Society Committee on Religion and Medicine, and the Catholic Physicians' Guild, this symposium is thought to be the first ever held on the ethical aspects of abortion. Speakers are internationally known authorities on the subject: Rev. Charles Carroll, Protestant Chaplain for Faculty and Students, University of California Medical Center in San Francisco, Calif.; Rabbi Martin Goldman, Dean, College of Jewish Studies and Maxwell Abbell Professor of Talmud, Chicago; and Rev. Charles Corcoran, Director, Aquinas Institute of Theology, Dubuque, Iowa. Moderator: Eugene Diamond, M.D., President, Catholic Physicians' Guild, and Clinical Professor of Pediatrics, Stritch School of Medicine, Loyola University, Chicago. The symposium will also feature an audience participation question and answer session.

ILLINOIS SURGICAL SOCIETY

Monday, May 20 Cook County Hospital
Chairman of the Surgical Symposium:
Louis P. River, M.D., Chicago

8:00-10:00 a.m. Surgical Amphitheatre
"Gastrectomy for Peptic Ulcer Disease"
Robert J. Baker, M.D., Associate Director of Surgery, Cook County Hospital.
Discussion: René Menguy, M.D., Professor and Chairman, Department of Surgery, University of Chicago School of Medicine; John T. Reynolds, M.D., Professor of Surgery, University of Illinois College of Medicine and Kent W. Barber, M.D., Quincy.

8:00-10:00 a.m. Opr. Room "A"
Moderator: James J. Callahan, M.D., Professor and Chairman of Department of Bone & Joint Surgery, Stritch School of Medicine, and Professor, Department of Bone & Joint Surgery, Cook County Graduate School.
"Open Reduction of Fractures"
J. Theodore Hartman, M.D., Surgeon
Discussion: Burton C. Kilbourne, M.D., Associate Professor of Surgery, University of Illinois College of Medicine; William Johnson, M.D., Galesburg, and Everett P. Coleman, M.D., Graham Hospital, Canton.

8:00-10:00 a.m. Opr. Room "B"
Moderator: Foster L. McMillan M.D., Clinical

Professor of Surgery, University of Illinois College of Medicine

"Colectomy for Cancer"

Peter A. Rosi, M.D., Professor of Surgery, Northwestern University Medical School
Discussion: Robert J. Patton, M.D., Springfield; Harris C. Putman, M.D., Chief of Staff, St. Francis Hospital, Peoria, and Clyde W. Phillips, M.D., Associate Attending Surgeon, Cook County Hospital, and Associate in Surgery, Northwestern University Medical School, Chicago

8:00-10:00 a.m. Opr. Room "C"
Moderator: William S. Dye, M.D., Associate Professor of Surgery, University of Illinois College of Medicine.
"Peripheral Vascular Surgery"
Robert J. Freeark, M.D., Chief of Surgery, Cook County Hospital, and Associate Professor of Surgery, University of Illinois College of Medicine
Discussion: John J. Bergan, M.D., Assistant Professor of Surgery, Northwestern University School of Medicine; Jack C. Cooley, M.D., Assistant Professor of Surgery, University of Illinois College of Medicine, and Gustav V. Giebelhausen, M.D., Peoria.

10:00-11:00 a.m. Hektoen Institute
Moderator: B. Marden Black, M.D., Professor of Surgery, Mayo Graduate School, and Consultant, Section on Surgery, Mayo Clinic, Rochester, Minn.
"Current Treatment of Nodular Goiter"
Case presentation and Discussion
Discussion: Louis P. River, M.D., Professor, Stritch School of Medicine, Loyola University, and William Requarth, M.D., Clinical Professor of Surgery, University of Illinois College of Medicine.

MEMBERS OF THE MEDICAL PROFESSION
ARE INVITED TO ALL SESSIONS—NO
REGISTRATION FEE

ILLINOIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Monday, May 20 Crystal Room

8:30 a.m.
Business Meeting of the Illinois Obstetrical-Gynecological Society
John J. Collins, M.D., presiding

9:00 a.m.
"Estimate of Fetal Maturity"
Roy M. Pitkin, M.D., Assistant Professor of Obstetrics & Gynecology, University of Illinois College of Medicine

9:30 a.m.
"Prevention of Rh-isoinmunization"
Eugene G. Hamilton, M.D., Associate Professor of Clinical Obstetrics & Gynecology, St. Louis University School of Medicine; Director of Department of Obstetrics & Gynecology, St. Mary's Hospital, St. Louis, Mo.

10:00 a.m.

"The Use of Heparin for Intravascular Coagulation in Obstetrics"

Alfred L. Keenan, M.D., Associate Professor of Obstetrics & Gynecology, University of Wisconsin Medical School

10:30 a.m.

Exhibit Break

10:45 a.m.

"Current Concepts of Toxemia"

W.R. Maloney, M.D., Carbondale

11:15 a.m.

"The Clinical Evaluation of Pap Smears and the Importance of Follow-up"

Abraham F. Lash, M.D., Ph.D., Director of Obstetrics & Gynecology, Cook County Hospital, Professor Emeritus, Northwestern University Medical School, Department of Obstetrics & Gynecology.

12:00 noon

Luncheon

Ruby Room 113

1:00 p.m.

Crystal Room

"Some Hormonally Active Lesions of the Human Ovary"

Arthur T. Hertig, M.D., Shattuck Professor of Pathological Anatomy, and Chairman, Department of Pathology, Harvard Medical School, Boston, Mass.

2:15 p.m.

Exhibit Break

2:30 p.m.

"The Physician as Consultant in Marital & Sexual Health"

Clark E. Vincent, Ph.D., Director of Behavioral Science Center, Professor of Sociology, Bowman-Gray School of Medicine, Winston-Salem, N.C.

OCCUPATIONAL HEALTH

Monday, May 20

Louis XVI Room

Opening Remarks: Edward C. Holmblad, M.D., Chairman, ISMS Occupational Health Committee

9:00 a.m.

"Status of Occupational Health in Illinois and Central States"

Arthur E. Sulek, M.D., Health Officer, City of Rockford and Winnebago County Health Departments

9:30 a.m.

"Evaluation of the Coronary Suspect"

Charles E. Thompson, M.D.

10:15 a.m.

"Non-organic Industrial Traumatic Diabetes"

Ben W. Lichtenstein, M.D., Cook County Hospital and University of Illinois

11:00 a.m.

Panel Discussion on "Medical Supervision of the Nurse and First Aid Team—Legal Responsibilities"

Panel: O. Tod Mallery, Jr., M.D., Medical Director, Employers Insurance of Wausau, Wis.; Mrs. Virginia Whalen, R.N., Occupational

Health Consultant, Liberty Mutual Insurance Co., Chicago; and Clare B. Schwartz, R.N., Employers Insurance of Wausau.

Question and answer periods will be scheduled between each section of the program.

ALCOHOLISM

Monday, May 20

Gold Room 114

9:00 a.m.

SECTION ON NEUROLOGY AND PSYCHIATRY

Monday, May 20

Louis XVI Room

Chairman: Harold E. Himwich, M.D., Galesburg
PSYCHIATRY: The Treatment of Mentally Disturbed Children & Adolescents

1:00 p.m.

"The Use of Psycho-active Drugs in Children"

Margaret Pijan, M.D., Pediatrician

Herman M. Adler Zone Center, Champaign

1:30 p.m.

Discussion

1:40 p.m.

"The Psychological and Biochemical Aspects of Drug Treatment in Adolescents"

Philip G. Ney, M.D., D.P.M., Child Psychiatrist

Herman M. Adler Zone Center, Champaign

2:10 p.m.

Discussion

2:20 p.m.

Exhibit Break

NEUROLOGY: Advances in Neurology

2:50 p.m.

"Clinical Impression and Neuro-Diagnostic Studies in The Diagnosis of Intra-Cranial Neoplasms"

Ivan S. Ciric, M.D., Instructor in Neurological Surgery, Northwestern University Medical School, and attending neurosurgeon, Evanston Hospital

3:10 p.m.

Discussion

3:20 p.m.

"Treatment of Glioblastoma Multiforme"

Richard Jelsma, M.D., Instructor, Department of Surgery, Northwestern University Medical School and Senior Resident in Neurological Surgery, Chicago Wesley Memorial Hospital

3:40 p.m.

Discussion

3:50 p.m.

"Recent Advances in the Treatment of Parkinsonism"

Joel Brumlik, M.D., Associate Professor, Department of Neurology and Psychiatry, Northwestern University Medical School, and Benjamin Boshes, M.D., Head of The Department of Neurology and Psychiatry, Northwestern University Medical School.

4:10 p.m.

Discussion

IMPAC ANNUAL MEETING

Monday, May 20
4:00 p.m.

Gold Room 114

SECTION ON SURGERY & ILLINOIS SURGICAL SOCIETY

Monday, May 20 Executive Ballroom—Mezzanine
Chairman: B. C. Kilbourne, M.D., Chicago

1:30-2:30 p.m.

"Motion Picture Presentation with Discussion of Operative Management of Hernia"

Moderator: John M. Beal, M.D., Professor and Chairman, Department of Surgery, Northwestern University Medical School

Panelists: Lloyd M. Nyhus, M.D., Professor and Chairman, Department of Surgery, Northwestern of Illinois College of Medicine; Kenneth H. Schnepf, M.D., Secretary, State of Illinois Examining Medical Board, and René Menguy, M.D., Professor and Chairman, Department of Surgery, University of Chicago School of Medicine

2:30-3:30 p.m.

"Hyperparathyroidism"

B. Marden Black, M.D., Professor of Surgery, Mayo Graduate School, and Consultant, Section on Surgery, Mayo Clinic, Rochester, Minn.

3:45-4:30 p.m.

"Discussion of Controversial Surgical Topics"

Moderator: George E. Block, M.D., Professor of Surgery, University of Chicago School of Medicine

Panelists: John M. Beal, M.D., Professor and Chairman, Department of Surgery, Northwestern University Medical School; Gerald W. Peskin, M.D., Chairman of Surgical Department, Michael Reese Hospital, and Robert E. Condon, M.D., Associate Professor of Surgery, University of Illinois College of Medicine

PUBLIC AFFAIRS DINNER CAMP MEMORIAL LECTURE

Monday, May 20

Bal Tabarin

6:00 p.m.

Reception & Dinner

8:00 p.m.

Camp Memorial Lecture

U.S. Senator George Murphy (R-Calif.)

SECTION ON ALLERGY

Tuesday, May 21

Gold Room 114

Chairman: Arnold A. Gutman, M.D., Chicago

8:30 a.m.

"Management of The Hypertensive Asthmatic Patient"

Donald Unger, M.D., Chicago, Clinical Assistant Professor, Department of Medicine (Allergy), Stritch School of Medicine, Loyola University

9:30 a.m.

"Serum Sickness: A Model of Immune Complex Disease"

Henry P. Russe, M.D., Columbus Hospital, Chi-

cago, Associate Clinical Professor of Medicine, Stritch School of Medicine, Loyola University

9:30 a.m.

"Mechanisms of Bronchoconstriction in Asthma"

Elliott Middleton, Jr., M.D., Attending Physician, Department of Medicine, Roosevelt Hospital, New York, and Assistant Clinical Professor in Medicine, College of Physicians and Surgeons, New York

10:30 a.m.

Exhibit Break

11:00 a.m.

"The Immunological Aspect of Allergy"

Raymond D. A. Peterson, M.D., Associate Professor, Department of Pediatrics, LaRabida University of Chicago Institute, Chicago

11:30 a.m.

"A Clinical Study of a Hypersensitivity Pneumonitis"

Jordan N. Fink, M.D., Assistant Professor of Medicine, Marquette University School of Medicine, Milwaukee, Wis., and Clinical Investigator, Veterans Administration

DIABETES IN PREGNANCY AND CHILDREN

Tuesday, May 21

Jade Room 103

9:00 a.m.

Panel Discussion: "Management of The Pregnant Diabetic Mother and The Newborn Infant"

Moderator: Joseph K. Skom, M.D., Assistant Professor of Medicine, Northwestern University Medical School, Chicago

Panelists: Marvin Cornblath, M.D., Chicago; Professor of Pediatrics, University of Illinois College of Medicine, and Albert Gerbie, M.D., Assistant Professor of Obstetrics and Gynecology, Northwestern Medical School, Chicago

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday, May 21

Ruby Room 113

Chairman: Thomas R. Wilson, M.D., Urbana

9:00 a.m.

"Obstetrical Anesthesia"

James Eckenhoff, M.D., Professor and Chairman, Department of Anesthesia, Northwestern University Medical School

9:30 a.m.

"Use of Drugs in Pregnancy"

Roy Pitkin, M.D., Assistant Professor of Obstetrics and Gynecology, University of Illinois College of Medicine

10:00 a.m.

"Hypertension During Pregnancy"

Frederick P. Zuspan, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, University of Chicago Medical School, and Chief, Department of Obstetrics and Gynecology, Lying-In Hospital, Chicago.

10:30 a.m.

"Management of Premature Rupture of the Membranes"

Augusta Webster, M.D., Professor of Obstetrics and Gynecology, Northwestern University Medical School

11:00 a.m.

"Chemotherapy and Ovarian Malignancy"

John G. Masterson, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Loyola University, Stritch School of Medicine.

11:30 a.m.

"Management of the Atypical Cytologic Smear"

Leon Carrow, M.D., Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School

SECTION ON PHYSICAL MEDICINE & REHABILITATION

Tuesday, May 21

Gold Room 114

Chairman: W. T. Liberson, M.D., Ph.D., Chicago
"SOME ASPECTS OF REHABILITATION OF THE GERIATRIC PATIENTS"

Moderator: W. T. Liberson, M.D., Professor and Chief, Sections of Physical Medicine and Rehabilitation, Loyola University, Stritch School of Medicine, and VA Hospital, Hines

1:30 p.m.

"Rehabilitation of Ambulation of Geriatric Patients (Following Amputations, Fractures, and Neurological Conditions)"

Mieczyslaw Peszczyński, M.D., Professor and Chairman, Department of Physical Medicine, School of Medicine, Emory University, and Director of Emory University Rehabilitation, Research and Training Center, Atlanta, Ga.

"REHABILITATION OF THE STROKE PATIENT"

"Pathology of Cerebral Vascular Disease"

Kevin D. Barron, M.D., Chief, Neurology Service, VA Hospital, Hines. Professor of Neurology and Psychiatry, Northwestern University Medical School, Chicago

"Clinical Neurological Examination and Management of Stroke"

Robert L. Tentler, M.D., Associate Clinical Professor, Loyola University, Stritch School of Medicine, Hines

"Neurosurgical Aspects"

Oscar Sugar, M.D., Professor of Neurological Surgery, College of Medicine, University of Illinois, Chicago

"Newer Rehabilitation Techniques"

W. T. Liberson, M.D., Ph.D., Professor and Chief, Sections of Physical Medicine & Rehabilitation, Loyola University, Stritch School of Medicine, and VA Hospital, Hines.

"Neurosurgical Management of Parkinsonian Patient"

Harold C. Voris, M.D., Chief, Section on Neurosurgery, VA Hospital, Hines, Chairman of the Section on Neurosurgery, Mercy Medical Center, Chicago and Clinical Professor of Neurosurgery, University of Illinois College of Medicine, Chicago.

"Psychiatric Aspects of the Rehabilitation of Geriatric Patients"

Jack Weinberg, M.D., Clinical Director of the Illinois State Psychiatric Institute and Clinical

Professor of Psychiatry, University of Illinois College of Medicine, Chicago.

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Tuesday, May 21

Ruby Room 113

Chairman: Fred Long, M.D., Peoria

2:00 p.m.

Panel Presentation

"COMPREHENSIVE HEALTH PLANNING"

Presiding: Fred Long, M.D.

"Public Law 89-749, Philosophy & Implementation"

James King, M.D., and James Phillips, U.S. Public Health Services, Region V

"AMA Activities Relating to Comprehensive Health Planning"

Clarke W. Mangun, Jr., M.D., Assistant Director, Department of Hospitals and Medical Facilities, AMA.

"Comprehensive Health Planning in Illinois"

Francis J. Weber, M.D., State of Illinois Department of Public Health

"Some Data on the Health Problems in Peoria"

Richard A. O'Connor, M.D., Peoria City and County Health Departments

PUBLIC HEALTH LUNCHEON

Tuesday, May 21

French Room 107

Noon

Luncheon—Illinois Academy of Preventive Medicine jointly with Section on Preventive Medicine and Public Health, Illinois Chapter—American Association of Public Health Physicians, and Illinois Association of Medical Health Officers. OPEN TO ALL PHYSICIANS

Presiding: Fred Long, M.D., Donaldson F. Rawlings, M.D.

"Toward a School of Public Health for Illinois"

Joseph S. Begando, Chancellor, University of Illinois Medical Center Campus.

SESQUICENTENNIAL LUNCHEON IN HONOR OF THE ILLINOIS STATE MEDICAL SOCIETY FIFTY-YEAR CLUB

Tuesday, May 21

Louis XVI

12:00 noon

Luncheon

"We War Perplexed by a Disease Cald Milksick"

(The story of the pioneers most dreaded plague)
W. D. Sniveley, Jr., M.D., Clinical Professor of Pediatrics, University of Alabama Medical Center, and Vice President of Medical Affairs, Mead Johnson Co., Evansville, Ind.

CONTINUING EDUCATION PROGRAM IN PSYCHIATRY FOR PHYSICIANS IN PRIVATE PRACTICE

(Sponsored by the Department of Psychiatry and Neurology of The Chicago Medical School, University of Health Sciences. Chairman and Professor: H. H. Garner, M.D.)

Tuesday, May 21

Jade Room 103

1:00 p.m.

Opening Remarks: H. H. Garner, M.D.

"Pseudoangina"

Philip Freedman, M.D., Professor and Chairman, Department of Medicine, The Chicago Medical School, University of Health Sciences

1:30 p.m.

Discussant

1:45 p.m.

Open Discussion

2:00 p.m.

Reply by Dr. Freedman

2:10 p.m.

Exhibit Break

2:30 p.m.

"Psychosomatic Aspects of Headache"

Seymour Diamond, M.D., Associate in Neurology and Psychiatry, Chicago Medical School, and Head, Headache Clinic, Mt. Sinai Hospital

3:00 p.m.

Discussant

3:15 p.m.

Open Discussion

3:30 p.m.

Reply by Dr. Diamond

SECTION ON RADIOLOGY

Tuesday, May 21

Crystal Room

Chairman: J. Homer Goodlad, M.D., Peoria

1:30 p.m.

"Methods of Radiological Diagnosis of Heart Disease"

Eugene Gedgaudas, M.D., Associate Professor of Radiology, and Director of Diagnostic Radiology, University of Minnesota, Minneapolis, Minn.

2:30 p.m.

Exhibit Break

3:00 p.m.

Panel Discussion

Moderator: Eugene Gedgaudas, M.D.

Panel Members: Wm. Sherrick, M.D., Memorial Hospital, Springfield; George Crickard, M.D., Blessing Hospital, Quincy; Constantine Soter, M.D., Arlington Heights; Maurice, Bogdonoff, M.D., Chicago.

4:30 p.m.

Business Meeting of the Illinois Chapter of the American College of Radiology

5:00 p.m.

Reception

SECTION ON E.E.N.T.

Wednesday, May 22

Crystal Room

HEAD AND NECK TRAUMA

8:30 a.m.

Introduction

Chairman: Emanuel M. Skolnik, M.D., Professor

of Otolaryngology, University of Illinois College of Medicine

"Blowout Fractures"

Eugene Folk, M.D., Assistant Professor of Ophthalmology, University of Illinois College of Medicine

"Facial (soft tissue) Trauma"

Morrison D. Beers, M.D., Clinical Assistant Professor of Plastic Surgery in the Department of Otolaryngology, University of Illinois College of Medicine

"Facial Bone Fractures"

Louis T. Tenta, M.D., Assistant Professor of Otolaryngology, University of Illinois College of Medicine

"Laryngeal and Tracheal Injuries"

George A. Sisson, M.D., Professor of Otolaryngology and Chairman of the Department, Northwestern University Medical School

"Middle Ear Injuries"

Ralph F. Naunton, M.B., B.S., Professor of Surgery and Chairman, Department of Otolaryngology, University of Chicago Medical School

"Inner Ear Trauma"

David F. Austin, M.D., Assistant Professor of Otolaryngology, University of Illinois College of Medicine

"Pathology of Ocular Trauma"

Milton M. Scheffler, M.D., Assistant Professor of Ophthalmology, Northwestern University Medical School

"Medicolegal Aspects"

Myron M. Hipskind, M.D., Clinical Professor of Otolaryngology and Chairman of the Department, Loyola University, Stritch School of Medicine

Panel Discussion

All participants on the program

SECTION ON PATHOLOGY

Wednesday, May 22

Gold Room 114

Chairman: Gerald S. Dean, M.D., Chicago
INTERPRETATION OF LABORATORY RESULTS

8:30 a.m.

"Factors Affecting the Reported Values of Laboratory Results"

Wendell T. Caraway, Ph.D., Biochemist, McLaren General Hospital, Flint, Mich.

10:15 a.m.

"Meaningful and Non-meaningful Values"

Clarence L. Gantt, M.D., Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

2:00-5:00 p.m.

Hektoen Institute

TISSUE SEMINAR

"Cytology"

Elizabeth Mc Grew, M.D., University of Illinois College of Medicine

SECTION ON PEDIATRICS

Wednesday, May 22

Louis XVI Room

Chairman: Ira M. Rosenthal, M.D., Chicago

Moderator: Alwin C. Rambar, M.D., Highland Park

9:00 a.m.

"The Immune System and Disease"

Raymond Peterson, M.D., Associate Professor of Pediatrics, University of Chicago, Director of Research, LaRabida University of Chicago Institute.

9:30 a.m.

"The Diagnosis and Treatment of Transposition of the Great Arteries"

Ian Carr, M.D., Assistant Professor of Pediatrics, University of Illinois College of Medicine, and Chief, Cardiovascular Laboratory, Cook County Children's Hospital. (*Dr. Carr's participation is sponsored by a grant from the Mead Johnson Laboratories.*)

10:00 a.m.

Exhibit Break

10:30 a.m.

"The Treatment of Infections in the Newborn Period"

Heinz F. Eichenwald, M.D., Professor and Chairman, Department of Pediatrics, University of Texas Southwestern Medical School, and Chief of Staff, Children's Medical Center, Dallas, Texas. (*Dr. Eichenwald's participation is sponsored by a grant from Eli Lilly and Company.*)

11:15 a.m.

"Drug Dependency in Adolescence and Children Including the Use of LSD and Marijuana"

Marvin J. Schwarz, M.D., Clinical Assistant Professor of Psychiatry, University of Illinois College of Medicine, and Child Psychiatrist, Presbyterian-St. Luke's Hospital and Cook County Children's Hospital.

SECTION ON DERMATOLOGY

Wednesday, May 22

Executive Ballroom

Chairman: Marshall L. Blankenship, M.D., Chicago

SUNLIGHT SYMPOSIUM

9:00 a.m.

"Physical Factors in Diseases Due to Light"

Frederick Urbach, M.D., Professor and Chairman, Department of Dermatology, Temple University School of Medicine, Philadelphia, Pa. (*Dr. Urbach's participation is sponsored by Merck Sharp & Dohme*)

10:00 a.m.

Exhibit Break

10:30 a.m.

"Polymorphous Light Eruptions"

John Epstein, M.D., Associate Clinical Professor of Dermatology, University of California, San Francisco, Calif.

11:15 a.m.

"Phototherapeutic Agents"

S. W. Becker, Jr., M.D., Clinical Associate Professor of Dermatology, University of Illinois College of Medicine, Chicago. (*Participation of Dr. Epstein and Dr. Becker is sponsored by Westwood Pharmaceuticals*)

**SECTION ON INTERNAL MEDICINE
& ILLINOIS SOCIETY OF
INTERNAL MEDICINE**

Wednesday, May 22

Old Chicago Room 101

Chairmen: Angelos P. Creticos, M.D., Chicago and A. Edward Livingston, Bloomington

9:00 a.m.

"Federal Programs: Comprehensive Health Planning and Regional Medical Programs"

Wright Adams, M.D., Professor of Medicine, University of Chicago, and Executive Director, Illinois Regional Medical Program, Office of Economic Opportunity

"Programs as They Affect the Disadvantaged Areas"

Francis L. Land, M.D., Commissioner, Medical Services, Administration, Social and Rehabilitation Services.

"Problems Confronting the Practicing Internist Relating to Various Health Programs Especially With Relationship to Established Medical Centers"

A. Edward Livingston, M.D., Bloomington

"A Physician Assessment Program"

Mervin Shalowitz, M.D., Associate Clinical Professor of Medicine, Stritch School of Medicine, Loyola University, Hines

**ILLINOIS SOCIETY OF
INTERNAL MEDICINE**

Wednesday, May 22

Jade Room 103

11:00 a.m.-12:00 noon

Reception

Noon

Luncheon

1:00 p.m.

Annual Meeting

William Ramsey, Executive Director, American Society of Internal Medicine

**FAMILY PHYSICIANS' LUNCHEON
of the
ILLINOIS ACADEMY OF
GENERAL PRACTICE**

Wednesday, May 22

Old Chicago Room 101

12:15 p.m.

Luncheon

PERIPHERAL VASCULAR DISEASE

Wednesday, May 22

Randolph Room

Moderator: Julius Conn, M.D., Chicago

2:00 p.m.

"Diagnostic Aids in Peripheral Vascular Disease"

John Marquardt, M.D., Associate in Medicine, Northwestern University Medical School, Chicago

2:10 p.m.

"Peripheral Aneurysms"

John J. Bergan, M.D., Assistant Professor of Surgery, Northwestern University Medical School, Chicago

2:20 p.m.

"Surgery in the Leriche Syndrome"

C. Frederick Kittle, M.D., Professor of Surgery, and Head of Section on Thoracic and Cardiovascular Surgery, University of Chicago Medical School, Chicago

2:30 p.m.

"Vascular Surgery for the Diabetic Patient"

Julius Conn, Jr., M.D., Associate in Surgery, Northwestern University Medical School, Chicago

2:40 p.m.

Discussion of Questions by Panel

Scientific Exhibits

S-1

Title: Benign Tumors Complicating Pregnancy
Exhibitors: Frederick H. Falls and Charlotte S. Holt
Institution: Illinois State Department of Public Health, Springfield
Description: Benign tumors are relatively uncommon, but for that reason when encountered during pregnancy they need more than ordinary diagnostic consideration because the physician in charge may overlook their presence and be unaware of the complications which they may produce and of the best clinical management to adopt to give both the mother and the fetus maximum protection. This possibility should be kept in mind by the physician at the first contact with the patient and should show in the history that previous knowledge of such abnormality was not known by the patient and if doubt is aroused in his mind, steps should be taken to confirm or deny such possibility by special means such as x-rays and consultation with the best available medical assistance. To this end, we have selected the most common and most dangerous of these tumors in order to awaken interest that may result in prophylactic measures being taken to successfully protect the health and happiness of two or more individuals.

S-2

Title: You Can Reduce
Exhibitors: Jeanne Braun, Mary Jane Kibler and Therese Mondeika
Institution: American Medical Association, Chicago
Description: "You Can Reduce" explores the imbalance between caloric intake and caloric expenditure which results in weight gain. The exhibit stresses the importance of applying sound principles to any weight reduction regimen. A calorically restricted diet must be adequate in all essential nutrients. Information is given on methods for determining ideal weight and sensible weight loss. The caloric values of various foods are listed.

S-3

Title: Physiologic Basis of Diuretic Therapy
Exhibitors: Albert N. Brest, Gaddo Onesti, Robert Seller, Charles Swartz and Asvaldo Ramirez
Institution: Hahnemann Medical College and Hospital, Philadelphia, Pa.

Description: This exhibit features the natriuretic and diuretic mechanisms of action exhibited by thiazides, mercurials, ethacrynic acid and furosemide, and the potassium-sparing drugs. Diuretic effects encountered under separate conditions of hydration and dehydration are compared, and relative potencies of diuretics, as determined by bioassay and acute weight loss studies, are described.

S-4

Title: Management of Leg Cramps of Peripheral Vascular Disorders
Exhibitor: Francis H. Stern, Philadelphia, Pa.
Description: A common complaint of geriatric patients with peripheral vascular ischemia is painful cramping of leg muscles, either of the intermittent claudication or nocturnal leg cramp variety. Papaverine selectivity relaxes smooth muscles, which relaxation appears to be more prominent if spasm exists; however, the muscle cell is not paralyzed and still responds to drugs and vasomotor stimuli. The anti-spasmodic effect is direct, unrelated to muscle innervation and is virtually devoid of effect on the central nervous system. The effectiveness of Papaverine Hcl (sustained release form) was studied in three double-blind crossover programs involving 25-30 geriatric patients presenting diverse vascular disturbances. The patients studied in two of these programs also presented diabetes mellitus.

S-5

Title: Low Disability with Facial Plastic Surgery
Exhibitor: Emanuel M. Herzon
Institution: Sherman Hospital, Elgin
Description: The exhibit consists of three panels consisting of a chart comparing the length of hospitalization of appendectomy cases to several varieties of facial plastic surgical cases. Facial plastic surgical techniques of rhinoplasty, face lifts, otoplasty, and dermabrasion are photographed covering operative procedures and pre- and post-op results included.

S-6

Title: Bronchogenic Carcinoma Masquerading as Inflammatory Disease Radiologically
Exhibitors: I. E. Kirsh, Blaz Korosec and Arnold Seitam

Institution: Veterans Administration Hospital, Hines

Description: Many of our patients with bronchogenic carcinoma sought admission when they got pneumonia; the first radiograph showed evidence of both diseases. The incidence of scar-cancer of the lung shows that chronic inflammations like TBC and fungus disease can have malignancy associated with them perhaps etiologically. Early Ca may resemble TBC. Examples of all of these are shown, with short clinical notes.

S-7

Title: How Aggressively Should Cancer be Treated?

Exhibitors: Harold B. Haley, Isabel R. Juan, and Jean F. Gagan

Institution: Loyola University Stritch School of Medicine, Hines

Description: The exhibit will describe the results of a 171-item questionnaire administered to 265 persons including 163 physicians regarding attitudes related to care of cancer patients. An outline of reasons for the study and of its underlying concepts and methodology will be shown as well as a statement of some results grouped under headings of diagnosis, management, patient's inner resources. Conclusions, pointing out consensus among doctors on many aspects and, on some aspects, differences of opinion between doctors and medical students and between doctors in different kinds of practice will be illustrated.

S-8

Title: Pathways to Better Clinical Pathology

Exhibitors: George F. Stevenson and Kenneth A. Schneider

Institution: Commission on Continuing Education of the American Society of Clinical Pathologists, Chicago

Description: Demonstration of programmed monographs in clinical pathology using the teaching machine. Review of Audiovisual seminars in all fields of clinical pathology. Stressing the Atlas Series obtainable only through the Commission on Continuing Education, cytology, pulmonary cytology, hematology, medical mycology. The teaching aids are available to all physicians, hospitals and medical schools. A complete library of manuals dealing with special phases of laboratory work will be displayed.

S-9

Title: Project Hope

Exhibitors: Geraldine M. Johnson, Arlene F. Kola and Candace K. Fischer

Institution: Project HOPE, Chicago

Description: The theme of this exhibit is Project Hope, U.S. at its best. Still photos and display letters carry Hope's message. Informational material is available.

S-10

Title: Recognition and Treatment of Hiatus Hernia

Exhibitors: Howard C. Baron and Leon Sasson

Institution: Jewish Memorial Hospital, New York, N. Y.

Description: Hiatus hernia is demonstrable in 11 per cent of patients examined by gastrointestinal series. It is a common cause of dyspepsia, chest pain, and gastrointestinal bleeding. The disorder is frequently not recognized and a correct diagnosis is missed. Patients with symptomatic hiatus hernias are frequently considered psychoneurotic, hypochondriacal or functionally dyspeptic. Modern diagnostic technics facilitate early diagnosis. Proper medical and surgical treatment can correct the pathophysiologic disturbances caused by the hernia. In this exhibit are presented etiologic factors, symptoms, and recognition by radiographic, endoscopic and pathophysiologic processes. The specific medical and surgical management is reviewed. The surgical procedure is illustrated with color transparencies of the operation supplemented by black and white line illustrations.

S-11

Title: Differential Diagnosis of Syphilis

Exhibitors: Samuel L. Andelman, Willard B. Fessenden, Jr., and Jerry Lama

Institution: Chicago Board of Health, V.D. Control Section, Chicago

Description: This exhibit utilizes a dimensional photographic process to depict the lesions of infectious syphilis in conjunction with other dermatological lesions. The objective of this exhibit is to raise the physician's index of suspicion and to alert him to the severity of the syphilis problem that exists in Chicago. An opportunity is also provided to discuss reporting, epidemiologic assistance and diagnostic assistance.

S-12

Title: Early Recognition of Rheumatoid Arthritis

Exhibitors: David L. Berens, L. Maxwell Lockie, Bernard M. Norcross, and Ru-Kan-Lin

Institution: Buffalo General Hospital, State University of New York at Buffalo, N. Y.

Description: Routine studies of hands, wrists and feet were done on fine-grain film during a six year period. Characteristic radiographic findings are often pres-

ent in asymptomatic joints which can contribute to the early recognition. Detailed, illustrated descriptions of these changes are correlated with the clinical, laboratory, and pathologic findings. Management of the early case is described.

S-13

Title: Community Child Care: The Role of the Neighborhood Health Center
Exhibitors: Joseph R. Christian, Albert L. Pisani, Iris R. Shannon
Institution: Mile Square Health Center of Presbyterian-St. Luke's Hospital, Chicago
Description: The development of the neighborhood health center under the sponsorship of the Office of Economic Opportunity represents a new approach to comprehensive family-oriented medical care for poverty areas. The Mile Square Health Center of Presbyterian-St. Luke's Hospital is the first neighborhood health center in the United States affiliated with a private hospital. It is located in a community one square mile in area, with a total population of 30,000, half of which are in the pediatric age group. The pediatric challenges presented by poverty areas and the approach used at Mile Square Health Center to meet these challenges are presented. Some of the concepts in this program are pioneer in nature and have been specifically designed to serve the needs of this particular type of community. Pediatric statistics covering the first six months of operation of the center are presented. These reveal the community's utilization of the center for child care and some of the problems faced and accomplished that have been made. The ultimate aims of this new approach to comprehensive family-oriented care within a neighborhood health facility are summarized.

S-14

Title: Mediastinoscopy
Exhibitors: Edward M. Goldberg and Ralph N. Bransky
Institutions: Michael Reese Hospital and Cook County Hospital; Chicago Medical School, Chicago
Description: The operative techniques employed in mediastinoscopy are demonstrated by the use of wax models showing related anatomy and a rubber model for simulated performance of the procedure. Illustrations, movies and x-rays are used to demonstrate indications and results in a wide range of pulmonary and mediastinal lesions.

S-15

Title: Prevention of Postoperative Intestinal Adhesions

Exhibitor: Robert L. Replogle
Institutions: Wyler Children's Hospital, Department of Surgery, University of Chicago School of Medicine, Chicago
Description: The prevention of intestinal adhesions occurring after abdominal surgery is a continuing problem. The incidence of this complication is particularly high in infants and has been observed as the most frequent cause of recurrent postoperative intestinal obstruction. A new method based on the administration of large doses of an antihistamine in conjunction with an adrenocortical hormone before and after surgery appears to afford great protection against the formation of intestinal adhesions. The exhibit presents details of a controlled study based on the pathophysiology of adhesion formation and outlines a clinical method which proved simple, safe and consistently effective for their prevention.

S-16

Title: A Precision System of Stereotactic Surgery
Exhibitors: Harold C. Voris, and Brian Baldwin
Institutions: Mercy Medical Center, Chicago
Description: This exhibit will present the latest model of the stereotactic apparatus which is currently being used at the Mercy Medical Center in Chicago. This apparatus permits operations on the patient in either the supine or the prone position and the placement of the lesions in either the pituitary fossa or the posterior cranial fossa. Further, the current phantom can be rapidly and quickly set in the operating room and the readings on the phantom apparatus transferred to the stereotactic apparatus used on the patient. Consequently, the procedure can now be carried out in one sitting in the operating room and with omission of the previous, somewhat complicated calculations necessary for the setting of the phantom.

S-17

Title: Shock and Its Effect on the Cell
Exhibitors: William Schumer and Richard Sperling
Institution: Veterans Administration, West Side Hospital, Chicago
Description: This exhibit shows that shock is a molecular disorder that concerns individual cells. It explains the anatomy of a cell and the function of each of its parts in relationship to this disorder. Normal cell biochemistry and energy demands are presented and these are compared with the changes that occur. A clear description is given of the metabolic derangements of shock and how these produce metabolic acidemia, cell malfunction and,

at times, cell death. Recently, knowledge about these phenomena has advanced significantly. Today it is often possible to reverse the process of cell damage and death due to shock. Therapy is reviewed on the basis of modern day well established concepts. The physician needs to understand the derangements that occur inside the molecules of a cell to more effectively control shock.

S-18

- Title:** Arthritis from an Orthopaedists's viewpoint
- Exhibitors:** Forrest H. Riordan, III, and Graham A. Kernwein
- Institution:** Rockford Memorial Hospital, Rockford
- Description:** The surgical and medical management including intra-articular and oral therapy for the treatment of rheumatoid arthritis, ankylosing spondylitis, osteoarthritis of the hip, back and knee as seen by the orthopaedist are presented in detail. The use of anti-inflammatory agents in the peri-articular tissues such as tendons and ligaments is also reviewed. Tables illustrating the clinical response, treatment schedules, medical illustrations, x-rays and color photographs comprise the graphic presentation.

S-19

- Title:** A Modified Dose Schedule for Broad Spectrum Antibiotic Therapy: Hypothesis and Practical Application
- Exhibitor:** Edward K. Isaacson
- Institution:** University of Illinois Medical Center, Chicago
- Description:** A twice-a-day dosage form of an antibiotic has certain obvious advantages. For demethylchlortetracycline such a schedule is feasible because it lingers in the circulating blood, having a low renal clearance, and being bound to plasma protein. A cross-over comparison has shown that therapeutic blood levels of demethylchlortetracycline can be maintained whether 600 mg. is administered as 300 mg. twice daily or as 150 mg. in four divided doses. In a clinical study of 50 patients, excellent results were achieved for 48 when demethylchlortetracycline was given on a twice-a-day dosage schedule.

S-20

- Title:** Eye Inflammations: Their Diagnosis and Treatment
- Exhibitor:** Robert G. Taub
- Institutions:** Children's Memorial Hospital and Columbus Hospital, Chicago, and Memorial Hospital, Michigan City, Ind.
- Description:** This exhibit pictures and describes the common inflammatory conditions of the eye. Treatment is discussed with

reference to the advantages and disadvantages of using a suspension, ointment or solution. In particular, the clinical efficacy and safety of a new, more soluble corticosteroid-antibiotic solution is assessed. Tonometric readings were made where possible. Generally, results were excellent.

S-21

- Title:** Extended Care Programs on the Community Level
- Exhibitors:** Marshall A. Falk and Herman Weiss
- Institutions:** Fox River Rehabilitation Center and Weiss Memorial Hospital, Chicago
- Description:** A not-for-profit Extended Care Facility shows its experience involving four years and almost 2,000 patients. The role of the family physician on a community level, involved in such an institution is stressed, and the team approach is emphasized. The average length of stay over this period was 23 days; 80 per cent were admitted from an acute general hospital and 20 per cent were admitted directly from home. At the time of discharge 75 per cent were sent home, 10 per cent to a nursing home and 14 per cent were sent back to the general hospital. Over 87 per cent of patients were followed by their own family physician. More than 1,000 patients received physical therapy. Programs are outlined from fractures, cerebral catastrophies, to post cardiac exercises. A slide show involving "Hearphones", showing a typical patient's experiences from the onset of patient's illness to discharge, is included. The role of the family physician in the care of the aged is stressed.

S-22

- Title:** Component Blood Therapy Means Better Patient Care
- Exhibitors:** John A. Shively and Charles J. A. Schulte, III
- Institutions:** American Association of Blood Banks, and United States Public Health Service, Department of Health Education and Welfare
- Description:** This exhibit's objective is to promote greater use of blood component therapy which, by its specificity, provides better patient care and conserves our human blood resources. The exhibit first presents the problem relating to the supply of and demand for these labile elements. Next, the methodology developed and employed by the modern blood bank to make these blood components available is graphically illustrated. Finally, practical guidelines for clinical usage are provided by the alignment of the specific components with their indications.

S-23

Title: The Temporal Bone Banks Program for the Study of Pathology in Disorders of Hearing and Equilibrium

Exhibitors: John R. Lindsay and Horst R. Konrad

Institution: University of Chicago, Chicago

Description: This exhibit on histopathology of the inner ear is divided into three sections. The first section demonstrates damage to the auditory and vestibular sense organs by the viruses of measles and mumps and the common cold. The second section illustrates the method of preparing the sections and the structures shown at different levels in the inner ear. This section is presented for orientation purposes. The last section demonstrates the pathology of sense organs of hearing and equilibrium secondary to several diseases of the bony labyrinthine capsule such as Letterer-Siwe's disease, Paget's disease, multiple granuloma due to diffuse arteritis and otosclerosis.

S-24

Title: Mediastinoscopy: An Experimental and Clinical Study

Exhibitors: Carl H. Johner, Paul H. Ward and Ralph F. Naunton

Institutions: University of Chicago, Chicago, and Vanderbilt University, Nashville, Tenn.

Description: The exhibit, by diagram and words, describes the development and technique of mediastinoscopy. An experimental study is described in which dogs were infected with histoplasma capsulatum and mediastinoscopy was performed as was scalene node biopsy, at varying intervals. Positive biopsy results from the two sources are compared. A series of patients on whom mediastinoscopy was performed is described with the results, indications and complications.

S-25

Title: Illness Induced and Improved by Drugs

Institution: The Medical Letter, New York, N.Y.

Description: This exhibit demonstrates the dual potential of drugs. Many diseases or symptoms which can be relieved or cured by some drugs can be induced or aggravated by others. The physician must always consider whether a drug which his patient has been taking is causing or contributing to his present complaint. The physician must also be aware of the diseases or symptoms which can be caused by the drugs he is thinking of prescribing. This exhibit illustrates six diseases often treated by drugs, but which can, themselves be induced by other drugs.

S-26

Title: Artificial Implantable Lung—Clotting and Intravascular Fibrin Deposition

Exhibitors: Louis R. Head, James M. Head, Bruce R. Bodell, Anthony J. Formolo, and Jay Steinberg, Chicago

Description: Intravascular clotting and fibrin deposition present a formidable obstacle to prolonged function of an implantable lung through destruction to blood flow, interference with gas transport by coating of the membrane-blood interface, and through peripheral embolization. The intention of this exhibit is to compare five systems of anticoagulation, studied in the laboratory for the prevention of clotting. This data is presented as pre- and post-implantation gas transport and flow calibration curves of a small capacity capillary tubing implantable lung. This work indicates that fibrin deposition and blood flow obstruction can be prevented and embolization minimized.

Scientific Motion Picture Schedule

NOTE: On Monday, May 20, the film program will start at 11:00 a.m. On Tuesday and Wednesday, the program will start at 9:00 a.m.

Morning Program

9:00 to 9:11 a.m.

THE INTRA-UTERINE DEVICE

Color, sound, 11 minutes. Prepared by George C. Denniston, M.D. and Walter L. Herrmann, M.D., Seattle.

This film describes in detail the technique of insertion of an intrauterine contraceptive device (Lippes Loop) currently being used in more than 60 countries through the world. The procedures for preparing the equipment and for the actual examination of the patient are included.

9:13 to 9:21 a.m.

CONGESTIVE HEART FAILURE

Color, sound, 8 minutes. Prepared by the American Heart Association.

This film corrects the misconceptions about the term "heart failure". Animated diagrams illustrate the work of the normal heart and circulatory system and help explain what happens when the heart fails to pump efficiently. Causes, symptoms, and treatment of heart failure are briefly discussed. The film emphasizes that congestive heart failure can be relieved or controlled by proper medical care.

9:23 to 9:48 a.m.

ROENTGEN ANATOMY OF THE NORMAL URINARY SYSTEM

Black and white, sound, 25 minutes. Prepared by J. Scott Dunbar, M.D. and M. B. Nogrady, M.D., Montreal.

This film uses segments of cinefluoroscopy, drawings, animation and narration to describe the normal anatomy of the urinary system as visualized by radiographic means.

9:50 to 10:11 a.m.

CLINICAL PROCTOSCOPY—ENDOSCOPIC STUDIES OF SIGMOID COLON, RECTUM AND ANAL CANAL

Color, sound, 21 minutes. Prepared by J. Peerman Nesselrod, M.D., Santa Barbara, Cal.

This motion picture is a revision of the film entitled "Sigmoid Rectum and Anal Canal Endoscopic Views" and is made in memory of Dr. Jay M. Garner. This is an endoscopic motion picture of various lesions of the lower bowel.

10:13 to 10:43 a.m.

THE MECHANISMS OF ACTION OF THE ORAL CONTRACEPTIVES

Color, sound, 30 minutes. Prepared by Edward T. Tyler, M.D. Los Angeles, Martin L. Stone, M.D., New York City and Melvin R. Cohen, M.D., Chicago.

This film involves a discussion of the effects of both combination and sequential oral contraceptives on the anterior pituitary, endometrium and the cervix. Dr. Tyler serves as moderator and discusses the ovulation inhibiting effect of both types of therapy. Dr. Cohen discusses the effect on cervical mucus, and Dr. Stone reviews the effects on the endometrium.

10:45 to 11:57 a.m.

DISEASES OF THE GALL BLADDER

Color, sound, 12 minutes. Prepared by Hilger Perry Jenkins, M.D., Chicago.

The purpose of this film is to show the varied nature of gall bladder disease as seen in the operating room, the surgical pathology laboratory and, in one instance, the morgue. A dozen cases are briefly presented to illustrate small and large gall stones, hydrops, empyema, gangrene, external fistula, carcinoma, adenomyoma and duplication.

11:00 to 11:38 a.m.

CLINICAL PATHOLOGICAL CONFERENCE—COOK COUNTY HOSPITAL, CHICAGO

Color, sound, 38 minutes. Prepared by Steven O. Schwartz, M.D., Paul B. Szanto, M.D. and Hildegarde A. Schorsch, M.D., Chicago.

This is an unrehearsed conference filmed as actually presented at the Cook County Hospital. To recreate the case presentation and discussion, the film is divided into two parts on a single reel. The case presented is that of an unemployed painter whose eyes began to turn yellow about one month prior to admission. On three previous hospital admissions the patient had been jaundiced; twice before he had delirium tremens.

Afternoon Program

2:00 to 2:34 p.m.

CLINICAL ENTITIES: CHRONIC BRONCHITIS AND EMPHYSEMA

Color, sound, 34 minutes. Prepared by John B. Hickam, M.D., Indianapolis, Ind.

This film presents the clinical entity embodied by pulmonary emphysema and chronic bronchitis. The basic pathological anatomy and physiology are presented. The film also discusses diagnosis and treatment and includes patients in various stages and variation of the entity.

2:36 to 3:01 p.m.

DIFFERENTIAL DIAGNOSIS OF CHEST PAIN

Color, sound, 25 minutes. Prepared by Richard Ross, M.D. and G. C. Friesinger, M.D., Baltimore, Md.

This film presents practical steps for the differential diagnosis of angina pectoris-like chest pain. The means for eliciting a meaningful patient history is introduced with lecture material and emphasized by dramatized physician-patient interviews. Relevant physical examination procedures and their rationale are discussed as is the relationship of angina pectoris to arteriosclerosis and ischemic heart disease.

3:03 to 3:35 p.m.

CLINICAL ENTITIES: HYPERTENSION OF ADRENAL ORIGIN—ALDOSTERONISM AND PHEOCHROMOCYTOMA

Color, sound, 32 minutes. Prepared by Peter H. Forsham, M.D., San Francisco, Cal.

These two different disorders of the adrenal glands are of vital importance because if they are diagnosed early, the hypertension caused by them can be cured. In the film, patients with these clinical entities describe their symptomatology. These symptoms are related to the underlying pathology of the disease entity and to the diagnosis. The approach is geared to the working tools available to the practitioner of medicine, particularly the history and physical examination. The electrolyte changes that occur in each entity are described and the hormonal defects are presented through animation techniques.

3:37 to 4:07 p.m.

DERMATOLOGIC OFFICE PROCEDURES FOR THE GENERAL PRACTITIONER

Color, sound, 30 minutes. Prepared by Gerald M. Frumess, M.D., Egbert J. Henschel, M.D. and Henry M. Lewis, M.D., Denver, Colo.

This film shows procedures that the general practitioner may use in his office practice. Electrosurgical and surgical removal of benign skin tumors, methods of biopsy, the use of solid carbon dioxide, patch testing, application of Unna's boot, and similar procedures are included.

Technical Exhibitors

Booths T-1, T-2 and T-3

DANIELS SURGICAL COMPANY

DANIELS—with Mid-America's Most Ultra Modern Facilities to serve your Modern Professional News will again feature the newest in "TOP LINE BRAND" equipment and supplies.

See our individual Model Office Displays—also consult with our Planning, Decorating, Financing, and Service Department at our exhibit.

NEW ITEMS TO BE SHOWN—A Fast New Office Procedure "Unitest" for Blood Glucose, B.U.N., Hemoglobin, Cholesterol, Uric Acid, Bilirubin, Total Protein-Globulin, Alkaline Phosphatase—L-F Uniflex Diathermy—RITTER #7 Speed-clave—New RITTER'S "75" Universal Table with full range 12-Positions Automatic Flexibility. HAMILTON'S New Electrically Operated Table—HAMILTON Modular Furniture—A Startling New Respirator Concept For Pulmonary Function—"RETEC"—Finger Tip Control "Electricator"—NEW Instant Finger Tip Adjustment Stools—Cassette Tape Recorders by DANCHI—Electronic Stethoscope—WELCH ALLYN Electrically Illuminated Diagnostic Instruments and the Newest in DISPOSABLE PRODUCTS. Descriptive Literature Is Available On All Products.

Booth T-4

ELI LILLY & COMPANY

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products. You may be particularly interested in discussing V-CILLIN K®, Potassium Phenoxymethyl Penicillin.

Booth T-5

AUDIO-DIGEST FOUNDATION

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in reel-to-reel tape and Phillips-type cartridges—General Practice, Surgery, Internal Medicine, Obstetrics & Gynecology, Anesthesiology, Ophthalmology and Pediatrics.

Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Co.

Booth T-6

ASTRA PHARMACEUTICAL PRODUCTS, INC.

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine) local and topical anesthetics, and iron preparations Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Booth T-7

EDISON VOICewriter DIVISION McGraw Edison Co.

Booth T-8

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

Booth T-9

MEDICINE & RELIGION

Booth T-10, T-11

GREGG COMMUNICATIONS, INC.

"Code-a-phone" Message Centers offer a complete range of telephone answering and recording services, plus the most versatile dictating system in the world. Message Centers can be used for after-hours phone calls, as a personal dictating machine and as a central or remote telephone dictation system.

Booth T-12

ROCK ISLAND COUNTY MEDICAL SOCIETY

Booth T-13

PFIZER LABORATORIES

Booth T-14

G. D. SEARLE & COMPANY

You are cordially invited to visit the SEARLE booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be information on Ovulen-21, Enovid, Aldactazide, Flagyl, Lomotil, Pro-Banthine and other drugs of interest.

Booth T-15

NEISLER LABORATORIES, INC.

Diutensen-R combines notably efficacious and markedly safe antihypertensive agents in convenient dosage form to provide the right combination for essential hypertension, a disease that demands multiple facets of therapy.

By utilizing three separate antihypertensive agents with a different avenue of attack, Diutensen-R provides dependable control of blood pressure at individual dosage below the side effect level of any component. Thus, the confusion of multiple prescriptions is avoided, and the total medication is provided to the patient at far less cost than if the ingredients were prescribed singly.

A Neisler technical representative is in attendance to discuss Diutensen-R.

Booth T-16
MINER MEDICAL INDUSTRIES, INC.

Booth T-17
THE DICTAPHONE COMPANY

For the busy doctor, Dictaphone presents the latest in office dictating and portable recording systems. Among physicians, the Time-Master dictating machine with in-built telephone recording is most popular together with the ultra-portable, battery powered Travel-Master and the new Series 810 magnetic model. For hospital use, Dictaphone features the Telecord system for network dictation by phone. Ideal for speedy, accurate medical record-keeping, the Telecord is also available with visible Dictabelt recording or magnetic recording media.

A new Autopsy dictation station featuring a hand-and-foot-free operation via electric eye will be of special interest to pathologists.

Booth T-18
**MEDICAL ARTS
SUPPLY COMPANY**

The Medical Arts Supply Co., in its 34 years of catering to the Doctor's needs, has established a reputation in the Medical Field. The honored names of eminent manufacturers such as Sklar, Hamilton, Ritter, Welch Allyn, Bausch & Lomb, Pelton, Burdick and many others have been the keyword of our reputation as quality dealers to the profession. We maintain a full interior decorating service for you and offer selection of only the finest.

Booth T-19
**ORMONT DRUG &
CHEMICAL CO., INC.**

The STERNEEDLE device provides a rapid, economical, painless method of screening a single patient or 450 per hour for Tuberculin Testing, Vaccination and Allergy Screening.

PANJET—a needle-free method for painless jet injection for anesthesia, steriods, etc. This instrument represents a major break through in medicine after many years of research and development.

Booth T-20
J. B. ROERIG & COMPANY

J. B. Roerig & Company will welcome members of the medical profession at the Company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you.

Booth T-21
KEY PHARMACAL CO.

Our booth display is a one piece unit designed to fit in this selected booth and we will have descriptive plaques on the following products: HYASORB penicillin, NITROGLYN, PROTERNOL, THEONAR, SEDUTAIN, CARBAMINE.

Booth T-22
7-UP DEVELOPERS

The organizations that bottle and deliver sparkling, crystal-clear 7-Up and LIKE to the people of Illinois will be represented at Booth #22. They will be ready at all times to provide the fresh, clean taste of chilled 7-Up and LIKE for thirsty conventioners.

Booth T-23
AYERST LABORATORIES

Ayerst Laboratories extends an invitation to visit our exhibit where PREMARIN and ATROMID-S are being featured. Our representatives will be pleased to discuss these or other Ayerst products with you.

Booth T-24
APACHE CORPORATION

The function of Apache Corporation is to organize, offer and manage drilling programs for individuals and corporations whose taxable incomes render attractive and justify the inherent risk of oil participation.

Booths T-25 and T-26
**BLUE SHIELD
ILLINOIS MEDICAL SERVICE**

Booth T-27
WALLACE PHARMACEUTICALS

We invite you to visit our booth where our representatives in attendance will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice.

Booths T-28 and T-29
PROCTER & GAMBLE CO.

This exhibit uses diagrams and demonstrations to show how Pampers, a new single-use diaper, keeps the infant drier than a cloth diaper. Also highlighted are the benefits to baby and mother derived from Pampers' unique design.

Booth T-30
**BEECHAM
RESEARCH LABORATORIES**

You are cordially invited to visit our exhibit featuring PENBRITIN (ampicillin), the new semi-synthetic broad-spectrum penicillin for wider use in major areas of infection.

Booth T-31
THE COCA-COLA COMPANY

Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Chicago and The Coca-Cola Company.

Booth T-32

WINTHROP LABORATORIES

Winthrop Laboratories cordially invites you to visit booth #32 where they will feature:
NEW!

Talwin® brand of Pentazocine (as lactate)

Booth T-33

ILLINOIS STATE-WIDE PUBLIC HEALTH COMMITTEE

Booth T-34

DOW CHEMICAL CO.

A new diagnostic system developed in conjunction with Bio-Science Laboratories of California for doing blood chemistry tests in a physician's office laboratory will be shown. The tests provide a convenient, accurate method for doing hemoglobin, glucose, urea nitrogen, cholesterol, uric acid and bilirubin determinations photometrically.

Booth T-35

ILLINOIS ASSOCIATION OF PROFESSIONS

Booth T-36

MEDICAL BUSINESS CONSULTANTS

Booth T-37

E. R. SQUIBB & SONS

Booth T-38

INVESTORS DIVERSIFIED SERVICES, INC.

Investors Diversified Services, Inc., with its subsidiary and affiliated companies, frequently referred to as the Investors Group, is unique among the nation's leading financial institutions. It is the largest investment corporation of its kind in the world . . . having currently more than six billion dollars in assets under management, and in excess of 1.4 million customer accounts. From its beginning in 1894 the company has maintained its own sales organization for the purpose of offering its securities directly to the public.

Booth T-39

SIEMENS MEDICAL OF AMERICA, INC.

SIEMENS MEDICAL will display many advancements in diagnostic and therapy equipment. Our representatives will be on hand to demonstrate our equipment and discuss practical applications with you. We believe a few minutes at our booth will prove to be well spent.

Booth T-40

PM-ILLINOIS, INC.

For over 35 years the PM GROUP has provided a complete business service for the medical profession. The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

You are cordially invited to stop and meet the experienced PM executives there.

Booth T-41

USV PHARMACEUTICAL CORPORATION

USV Pharmaceutical Corporation is proud to be at the 1968 Illinois State Medical Society Convention.

Our technically trained personnel are available to provide information on our new products. We look forward to greeting you at our exhibit booth, 41.

Mr. Naim Bajjalieh, Attending

Booth T-42

ARNAR-STONE LABORATORIES, INC.

AMERICAINE TOPICAL ANESTHETIC—20% dissolved benzocaine in a water-soluble base—ointment, suppositories and aerosol forms.

HAZEL-BALM—cooling, soothing witch hazel and emollient lanolin in aerosol form—provides a comforting "cushion of foam."

ISOCOLOR—oral nasal decongestant and bronchodilator—tablet, liquid and timesule forms, also the anti-tussive Isoclor expectorant.

SOPOR—Non-barbituate hypnotic sedative for gentle untroubled sleep. Particularly useful with geriatric patients.

Booth T-43

FLINT LABORATORIES, INC.

Featured will be FLINT Laboratories' newly introduced CHOLOXIN® (sodium dextrothyroxine) which effectively lowers elevated serum cholesterol. Also featured will be HU-TET® (tetanus immune globulin, human), the homologous tetanus antitoxin and SYNTHROID® (sodium levothyroxine) indicated in hypothyroidism.

Booth T-44

PARKER, ALESHIRE & CO.

As the administrators of the officially sponsored Group Disability Plan and Group Major Medical Plan for members of the Illinois State Medical Society, we invite you to drop by our booth and discuss these fine programs with our representatives.

Both plans provide broad coverage that cannot be duplicated under an individual policy at the comparable premium cost to you. Review your group insurance needs today.

These programs are another benefit of your membership in the Illinois State Medical Society and deserve your consideration.

Booth T-45

CIBA PHARMACEUTICAL COMPANY

CIBA Professional Service Representatives will be pleased to discuss Ritalin.

Booth T-46

MEDCO PRODUCTS CO., INC.

Presenting the new MEDCO-SONLATOR TWIN, a new concept in therapy. Combining the first significant advance in Ultrasound therapy, selective rate pulsed Ultrasound, synchronized with Muscle Stimulation, and simultaneously applied through a single 3-way sound applicator. A few minutes spent in our booth should prove of value to your practice.

Booth T-47

WM. P. POYTHRESS & CO., INC.

TROCINATE—a new concept in smooth muscle spasmolysis, acting directly upon muscle cells. Not an anticholinergic. No side-effects characteristic of autonomic blocking drugs. High therapeutic index. Trocinate is particularly effective against functional diarrhea, mucous colitis, diverticulitis, spastic ureteritis and bladder spasm. No significant side-effects have ever been reported.

Booth T-48

SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display at booth 48, where we are featuring Mellaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Booth T-49

SMITH KLINE & FRENCH LABORATORIES

Featured will be our comprehensive oral diuretic, 'Dyazide', each capsule containing 50 mg. of 'Dyrenium' (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Booth T-50

PARKE, DAVIS & CO.

You are cordially invited to visit the Parke-Davis exhibit which features two products—Norlestrin® 1 mg. and Ponstel® (mefenamic acid).

Booth T-51

LEDERLE LABORATORIES

Lederle Laboratories is proud to support the 1968 Convention of the Illinois State Medical Society. As one of the leaders in medical research and quality

controlled production, we present for your consideration products such as LEVOPROME®, DECILOMYCIN®, ACHROMYCIN® V, ARISTOCORT®, DECLOSTATIN®300, and others applicable to your practice. Our representatives are also prepared to provide information on our numerous services to medicine.

Booth T-52

ABBOTT LABORATORIES

Abbott Laboratories will feature the following products: Erythrocin®, an antibiotic or unparalleled safety and known bactericidal action against many common pathogens; Normosol solutions, modern successors to normal saline, dextrose in water, and dextrose in saline; Antihypertensive "Building Block" products covering treatment of the full spectrum of benign essential hypertension, from mild to moderate to severe.

Booth T-53

THE UPJOHN COMPANY

Professional representatives of the Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Booth T-54

MILLER PHARMACAL COMPANY

Products designed to support the extra requirements of the body's hundreds of enzyme systems for minerals, vitamins and amino acids during periods of stress and subnormal nutrition. Because of their satisfaction in prophylaxis and therapy, patients appreciate these truly scientific preparations—CARDENZ, CHENATAL, Fe-PLUS, HYALEX, LYSMINS, Mg-PLUS, Mg-PLUS "C", NUCLOMINS, RAGUS, SCLEREX, ULCIMINS.

Booth T-55

ENCYCLOPAEDIA BRITANNICA, INC.

Encyclopaedia Britannica welcomes all delegates to the Illinois State Medical Society and invites them to examine the great new edition of Britannica.

Official delegates may now purchase this magnificent set at an offer only available at our convention exhibits.

Booth T-56

THE MEDICAL PROTECTIVE COMPANY

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of over 94,000 claims during 69 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Booth T-57

GEIGY PHARMACEUTICALS

Geigy Pharmaceuticals cordially invites members and guests of the association to visit its exhibit. The exhibit features important new therapeutic developments in the management of Cardiovascular Disease as well as current concepts in the control of Inflammation; Hypertension and Edema; Depression; Obesity, and other disorders, which may be discussed with representatives in attendance.

Booth T-58

MERCK SHARP & DOHME

The Merck Sharp & Dohme exhibit has been designed to supplement the physicians therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Booth T-59

W. B. SAUNDERS COMPANY

New Saunders books since last year's meeting include: Beattie and Economou: Atlas of Advanced Surgical Techniques; Williams: Endocrinology; Hamberger-Walsh: Nephrology; Trueta: Studies in the Development and Decay of the Human Frame; and Conn: Current Therapy, 1968.

Booth T-60

MEAD JOHNSON LABORATORIES

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Booth T-61

CONTOUR CHAIRS CO.

Booth T-62

UNITED MEDICAL LABORATORIES, INC.

Thoughtfully selected profile studies yield information not obtainable from history and physical examination alone. Repeated tests establish a normal chemical and metabolic profile for a given individual. Noting early changes in the patient's laboratory pattern, as compared to their normal base line, helps to detect disease before serious physical changes have occurred.

Booth T-63

SESQUICENTENNIAL EXHIBIT



If your patients can't have the real thing...



Let them have the next best thing.

For salt-free dieters, the next best thing is new Morton Salt Substitute. It's sodium-free, but it tastes like the real thing. After all, we've been producing the real thing for over 58 years. So, we know what real salt flavor is. Let your patients on salt-free diets enjoy better flavor by suggesting new Morton Salt Substitute.

NEW PRODUCTS

Robinul® (glycopyrrolate) Injectable, a new companion product to the oral dosage forms of Robinul (glycopyrrolate), was introduced Sept. 1 by A. H. Robins Co., Richmond-based pharmaceutical manufacturer.

Robinul Injectable will be available in 1 cc. ampuls and 5 cc. multiple-dose vials.

Each 1 cc. contains glycopyrrolate, 0.2 mg., and water for injection, USP, q.s., with chlorobutanol, 0.5%, as the preservative.

The parenteral dosage form of this anticholinergic is offered for those patients who are unable to tolerate oral medication or in those clinical situations where rapid anticholinergic action is desired. Detailed information concerning the use and administration of this prescription drug is contained in the package insert.

* * *

Roche Laboratories, Division of Hoffmann-La Roche Inc., has just announced the availability of Libritabs (chlordiazepoxide) in bottles of 500.

The use of Libritabs (chlordiazepoxide) is indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Detailed information on dosage, contraindications, warnings, precautions and adverse reactions is contained in the package insert.

Libritabs (chlordiazepoxide) are available in green tablets in three strengths with "Roche" embossed on one side and the mg strength on the other: 5 mg, 10 mg or 25 mg chlordiazepoxide.

* * *

Tybatran™ (tybamate), a tranquilizing agent, was introduced Sept. 1 by A. H. Robins Co., Richmond-based pharmaceutical manufacturing firm.

The green, soft gelatin capsules will be available in strengths of 125 mg., 250 mg., and 350 mg. Each strength will be supplied in bottles of 100 and 500.

Tybatran is offered for a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Detailed information concerning the use and administration of this prescription drug is contained in the package insert.

* * *

A new topical corticosteroid for treatment of allergic and inflammatory disorders of the skin was recently made available to physicians by Schering Laboratories, a division of Schering Corporation.

Marketed under the trade name of Valisone (betamethasone 17-valerate), and available only on prescription, the drug is

(Continued on page 547)



J. W. Nelson, Jr., general manager, General Electric Co. (center), holding plaque containing five millionth film badge delivered by Nuclear-Chicago Corporation, a subsidiary of G. D. Searle and Co. The device is used to monitor personnel radiation exposure in fields of medicine, dentistry and education. The film badge division of Nuclear-Chicago has been providing Nuclibadge® service for more than 15 years. From the left are E. G. Hofer, Director of the film badge division; J. L. Kuranz, executive vice president of Nuclear-Chicago; Nelson; J. A. McGown, manager of manufacturing for G.E., and D. W. Day, General Electric's manager of medical marketing.

Night Leg Cramps . . . Unwelcome Bedfellow In Diabetes¹, Arthritis², and Peripheral Vascular Disorders²



now . . . specific therapy for night leg cramps

Walker

QUINAMMTM

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.³ Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: **Composition:** Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

Clinics for Crippled Children

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 18 general clinics providing diagnostic, orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 1, Hinsdale, Hinsdale Sanitarium

May 2, Sterling—Community General Hospital

May 2, Litchfield—Madison Park School

May 2, Peoria Cerebral Palsy (A.M.), Zeller Zone Center

May 7, Fairfield, Fairfield Memorial Hospital

May 7, Alton General, Alton Memorial Hospital

May 8, Champaign-Urbana, McKinley Hospital

May 8, Joliet—St. Joseph's Hospital

May 9, DuQuoin, Marshall-Browning Hospital

May 9, Springfield General, St. John's Hospital

May 10, Chicago Heights Cardiac, St. James Hospital

May 14, East St. Louis, Christian Welfare Hospital

May 14, Pittsfield—Illini Community Hospital

May 14, Peoria General, Children's Hospital

May 15, Evergreen Park, Little Company of Mary Hospital

May 16, Rockford, Rockford Memorial Hospital

May 16, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

May 16, Elmhurst Cardiac, Memorial Hospital of DuPage County

May 22, Centralia—St. Mary's Hospital

May 22, Rock Island Cerebral Palsy, Foundation for Crippled Children & Adults, 3808 Eighth Ave.

May 22, Elgin—Sherman Hospital

May 23, Decatur, Decatur & Macon Co. Hospital

May 24, Chicago Heights Cardiac, St. James Hospital

May 28, Peoria General, Children's Hospital

May 29, Springfield Cerebral Palsy (P.M.)—Diocesan Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and others.

Roche Laboratories to Date All Products

Roche Laboratories, division of Hoffmann-La Roche Inc., has decided to put an expiration date on the label of all of its products—both prescription drugs and over-the-counter specialties.

For the first time, all products of a major pharmaceutical company will thus provide the added protection inherent in an expiration date on each package.

Up to now, the label has provided a code which permits identification of each batch as well as the date of manufacture. This code will continue to be used but, in addition, the dating—established for each product in accordance with the results of

stability tests extending over a period of years—will provide a further safeguard.

The use of an expiration date has hitherto been limited to some liquid products with a limited shelf life since tablets and capsules usually retain their full potency well beyond the limits required by normal distribution channels. The adoption of an expiration date provides additional assurance of full potency for each package of each product.

The transition to dated packages will be carried out gradually, as current stocks become exhausted.

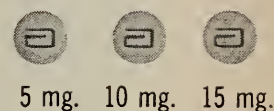
That's why Abbott offers you a pill plus a program.



The Product

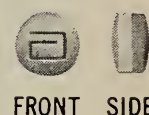
*For smooth appetite
control plus mood
elevation*

DESODYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

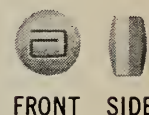


*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

INDERAL Cardiac Depressant R

Manufacturer: Ayerst Laboratories

Nonproprietary Name: Propranolol HCl

Indications: Cardiac arrhythmias, hypertrophic sub-aortic stenosis, pheochromocytoma.

Contraindications: Bronchial asthma, allergic rhinitis (during pollen season), sinus bradycardia and greater than second degree heart block, cardiogenic shock, right ventricular failure secondary to pulmonary hypertension, congestive heart failure, patients receiving anesthetics that produce myocardial depression, and those on adrenergic-augmenting psychotropic drugs, and during the two week withdrawal period from such drugs.

Dosage: Oral—10 to 40 mg. three or four times daily.

Supplied: Tablets—10 and 40 mg., bottles of 100 and 1000.

DUPLICATE SINGLE PRODUCTS

CERESPAN Antispasmodic R

Manufacturer: USV Pharmaceutical Corp.

Nonproprietary Name: Papaverine HCl

Indications: Prophylactic treatment of cerebral ischemia due to vasospasm.

Contraindications: None mentioned.

Dosage: One capsule bid. May be incr. to 1 caps. tid, or 2 caps. bid.

Supplied: Capsules—150 mg. (sustained release), bottles of 100.

MUMPSVAX Biological R

Manufacturer: Merck Sharp & Dohme

Nonproprietary Name: Mumps virus vaccine, Jeryl Lynn strain, live, attenuated.

Indications: Immunization against mumps virus.

Contraindications: Hypersensitivity to eggs, chicken, chicken feathers or neomycin; during pregnancy; in individuals with various chronic and infectious diseases.

Dosage: 1/2 cc., s.c.

Supplied: Disposable syringe, with poder and diluent 1/2 cc.

COMBINATION PRODUCTS

AYR CAPSULES Bronchial Dilator R

Manufacturer: B. F. Ascher & Co.

Composition: Theophylline 260 mg.

Pseudoephedrine 50 mg.

Butabarbital 15 mg.

Indications: Symptomatic relief of respiratory disorders accompanied by bronchospasm, such as asthma, asthmatic bronchitis, pulmonary emphysema.
Contraindications: Hypersensitivity to any of the ingredients.

Dosage: One capsule bid.

Supplied: Capsules (sustained release), bottles of 100 and 500.

AYR Liquid Bronchial Dilator

R

Manufacturer: B. F. Ascher & Co.

Composition: Each 15 cc. contains:

Theophylline	130 mg.
Pseudoephedrine	25 mg.
Butabarbital	8 mg.
Alcohol	20 %

Indications: Symptomatic relief of respiratory disorders accompanied by bronchospasm, such as asthma, asthmatic bronchitis, pulmonary emphysema.

Contraindications: Hypersensitivity to any of the ingredients.

Dosage: One tbsp. q4h, 3 or 4 times a day.

Supplied: Liquid, pint bottles.

AYR Tablet Bronchial Dilator

R

Manufacturer: B. F. Ascher & Co.

Composition: Theophylline 100 mg.
Glyceryl Guaiacolate 100 mg.

Indications: Symptomatic relief of respiratory disorders accompanied by bronchospasm, such as asthma, asthmatic bronchitis, pulmonary emphysema.

Contraindications: Hypersensitivity to any of the ingredients.

Dosage: One or two tablets, 3 or 4 times a day.

Supplied: Tablets, bottles of 100 and 500.

ELASE-CHLOROMYCETIN Oint.

Antibiotics—Topical

R

Manufacturer: Parke, Davis & Co.

Composition: Chloramphenicol 1 %
Fibrinolysin, Bovine 1 unit/Gm.
Desoxyribonuclease 666.6 units/Gm.

Indications: Wounds or lesions infected with susceptible organisms, where enzymatic debridement action is also desired.

Contraindications: None mentioned.

Posage: Must be individualized.

Supplied: Ointment, 10 Gm. and 30 Gm. tubes.

STUART PRENATAL

R

w. Folic Acid Vit./Min. Comb.—Prenatal

Manufacturer: The Stuart Co.

Composition: Ten vitamins and seven minerals.

Indications: Supplemental vitamins and minerals for use during pregnancy and lactation.

Contraindications: None mentioned.

Dosage: One tab. daily after meal, or as directed by physician.

Supplied: Tablets—bottles of 100.

NEW DOSAGE FORMS

INDERAL (Injectable) Cardiac Depressant

R

Manufacturer: Ayerst Laboratories

Nonproprietary Name: Propranolol HCl

Indications: Cardiac arrhythmias, hypertrophic sub-aortic stenosis, pheochromocytoma.

Contraindications: Bronchial asthma, allergic rhinitis (during pollen season), sinus bradycardia and greater than second degree heart block, cardiogenic shock, right ventricular failure secondary to pulmonary hypertension, congestive heart failure, patients receiving anesthetics that produce myocardial depression, and those on adrenergic-augmenting psychotropic drugs, and during the two week withdrawal period from such drugs.

Dosage: I.V.—1 to 3 mg. administered under ECG monitoring.

Supplied: Ampuls—1 mg./cc., boxes of 10.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.

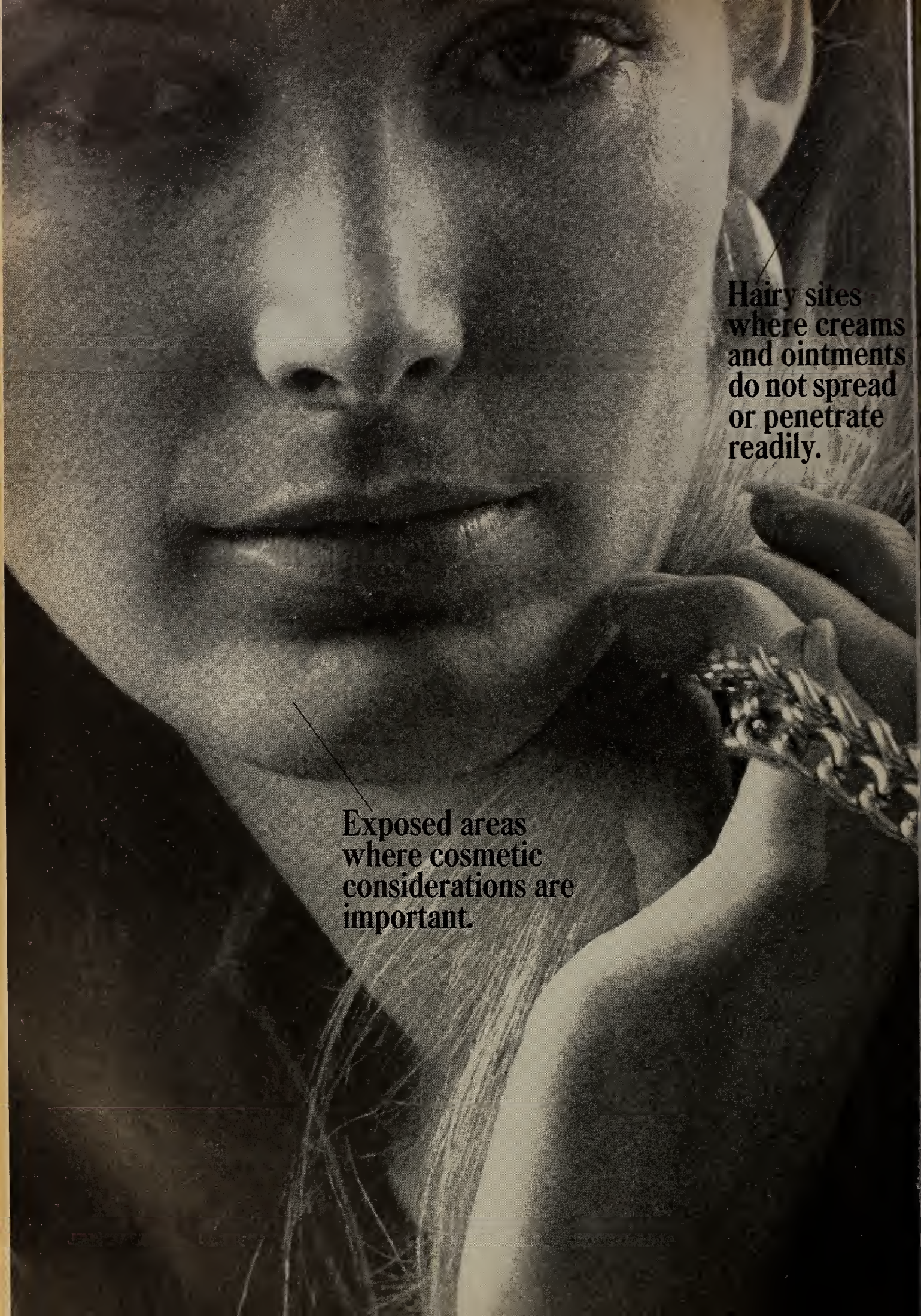
warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Children's Dose: One or two teaspoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



Hairy sites
where creams
and ointments
do not spread
or penetrate
readily.

Exposed areas
where cosmetic
considerations are
important.

Cosmetically acceptable for exposed areas.

The propylene glycol vehicle of Synalar Solution possesses many useful cosmetic properties. Clear and greaseless, it is not sticky or messy, will not stain clothing or skin.

In exposed areas of the body where cosmetic appeal is important, Synalar Solution shows nothing but results.

Economical—a little goes a long way.

Because of the properties of propylene glycol and the milligram potency of fluocinolone acetonide, a small quantity of Synalar Solution goes a long way. Also, the prescription price of a 20 cc. plastic squeeze bottle of Synalar Solution is surprisingly low. Thus, your patients obtain economy with the proved efficacy of a potent, truly advanced topical corticosteroid.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all

drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. Also available: Synalar (fluocinolone acetonide) Cream 0.025% — 5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01% — 15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025% — 15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream — 5, 15 and 60 Gm. tubes.

fluocinolone acetonide — an original steroid from
SYNTEX 
LABORATORIES INC., PALO ALTO, CALIF.

Synalar® (fluocinolone acetonide) Solution 0.01%

An invisible topical



ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT



Annual Meeting in Belleville

By JEAN BERSCHINSKI

The Illinois Medical Assistants Association will hold its annual meeting at Augustine's Motor Lodge in Belleville, April 19-21.

Mrs. Dorothy Koch, convention committee chairman, has announced that business meetings will be held April 19 with professional education programs April 20. A breakfast session will be one of the highlights of the April 21 program.

A banquet, April 20, will be highlighted by the installation of Mrs. Helen Smith, McHenry County, as president of the 500-member organization.

Mrs. Smith, medical assistant to Dr. Arnold Curnyn of Elk Grove Village, will succeed Mrs. Synobia Payne, Chicago.

The proposed slate of candidates for other offices include: Mrs. Zelma Bechtol, Lake County, president-elect; Miss Ina Yenerich, Kane County, 1st vice-president; Mrs. Ann Newingham, Peoria, and Mrs. Mary Siers, St. Clair County, 2nd vice-president; Miss Phyllis Bredthauer, Kane County, recording secretary; and Mrs. Luella Mitchell, Cook, treasurer.

Also to be elected are one delegate and three alternate delegates.

Dr. Thomas R. Harwood, Highland Park, chairman of the ISMS advisory committee to IMAA, urges physicians to send their medical assistants to the meeting which he described as "very valuable and worthwhile."

APPLICATION FOR TERM LIFE INSURANCE to PROFESSIONAL LIFE & CASUALTY COMPANY, CHICAGO, ILLINOIS

1. Full Name of Applicant _____									
Date of Birth _____		Mo. _____		Day _____		Year _____		Place of Birth _____	
								City _____ State _____	
2. Height _____		Weight _____		3. <input type="checkbox"/> Male, <input type="checkbox"/> Female		4. <input type="checkbox"/> Married, <input type="checkbox"/> Single, <input type="checkbox"/> Divorced, <input type="checkbox"/> Separated			
5. PERMANENT MAILING ADDRESS _____									
Street Address _____						City _____ State _____ Zip _____ (No. of Yrs. _____)			
6. Medical School: _____									
Name _____						City & State _____			
Date Entered Medical School _____									
7. AMOUNT OF INSURANCE: 10 YEAR CONVERTIBLE* TERM OR 15 YEAR CONVERTIBLE* TERM									
<input type="checkbox"/> \$10,000.00					<input type="checkbox"/> \$10,000.00				
<input type="checkbox"/> \$20,000.00					<input type="checkbox"/> \$20,000.00				
*Convertible to participating Whole Life Insurance at any time prior to the end of the Term period.									
8. PREMIUMS PAYABLE: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Other _____ Premium: \$ _____									
9. DISPOSITION OF ANNUAL DIVIDENDS: <input type="checkbox"/> Pay in Cash <input type="checkbox"/> Accumulate at Interest <input type="checkbox"/> Apply to Premium									
10. Beneficiary _____									
Name in Full _____						Relationship _____			
11. Do you know of any impairment now existing in your health or physical condition? Yes _____ No _____ If "yes" give particulars _____									
12. Have you consulted a physician for illness during the past three years? Yes _____ No _____ If "yes" give particulars _____									

I HEREBY APPLY for insurance described above and agree to pay premiums therefor at the rate shown above.

INFORMATION in this application is given to obtain this insurance and is true and complete to the best of my knowledge and belief. The Company shall incur no obligation because of this application unless and until it is approved by the Company and the first premium is paid in full while my health or other conditions affecting my insurability are as described in the application.

Date _____

Signature of Applicant _____

Start your program of insurance protection today, while premiums are low with a Term-Life Plan that meets today's needs with a protective look towards the future.

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Your Annual Premium is based on your age at issue (nearest birthday) and remains the same for the duration of the policy. It cannot be changed by the Company.

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You may select either \$10,000 or \$20,000 of life insurance. Your insurance will continue for the amount and term you select (10 year or 15 year term period) and cannot be reduced or terminated by the Company.

GUARANTEED CONVERSION

Your term policy may be converted to our Participating Whole Life Plan at any time during the policy period without any restrictions or limitations.

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Your Term Plan guarantees you the right to obtain PLC's participating Whole Life Plan which has been rated the No. 1 "low net cost" plan by a nationwide statistical service.

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GUARANTEED CONVERTIBLE TERM INSURANCE				
Premiums for \$10,000 POLICY				
Age At Issue (Nearest Birthday)	10 YEAR TERM		15 YEAR TERM	
	Annual	Semi-Annual	Annual	Semi-Annual
21	\$33.00	\$17.00	\$34.00	\$17.50
22	33.50	17.50	34.50	18.00
23	34.00	17.50	35.00	18.00
24	34.50	18.00	35.50	18.50
25	35.00	18.00	36.00	18.50
26	35.50	18.50	36.50	19.00
27	36.00	18.50	37.50	19.50
28	36.50	19.00	38.50	20.00
29	37.00	19.50	40.00	21.00
30	37.50	19.50	42.00	22.00

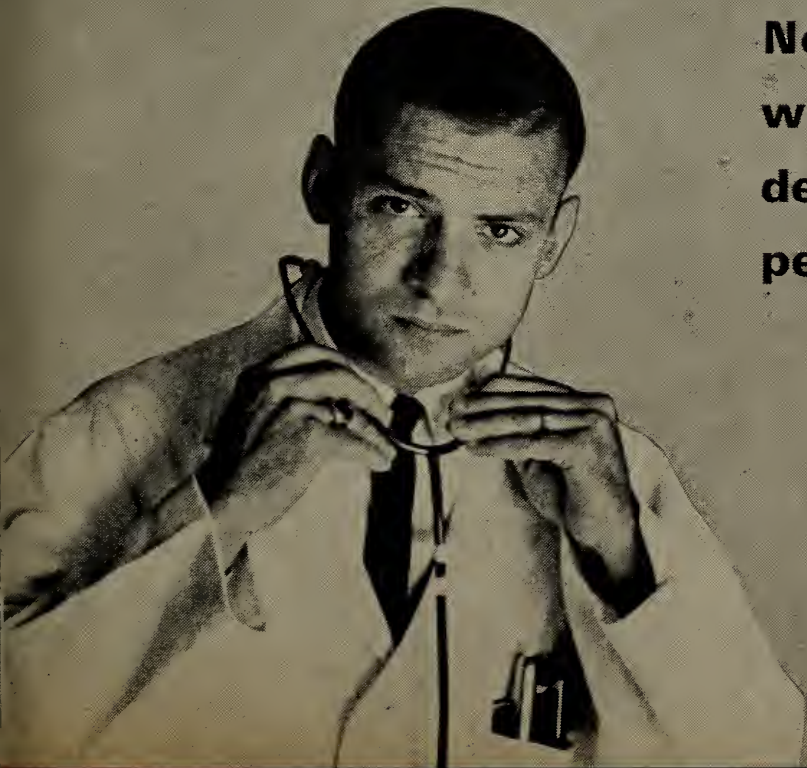
-Premiums for \$20,000 Policy are double the above rates
-Premiums for Ages not shown will be provided on request



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Now we have a Term-Life Plan with premiums you can afford, designed for conversion to permanent life protection.

Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093—Telephone (312) 446-8440.

Genetic Counseling

Genetic counseling, aimed at helping to prevent certain inherited diseases, should be made compulsory, according to the University of Chicago.

Dr. Mehran Goulian, one of two researchers who recently succeeded in manufacturing the material that controls heredity, made his assertion on the television discussion series, "The University of Chicago Round Table."

Dr. Goulian said, "At the moment we're in a period of lag between the available information and the propagation to the people concerned. I don't really see the harm in making this compulsory."

Appearing with Dr. Goulian were George W. Beadle, President of The University of Chicago and 1958 Nobel laureate in medicine and physiology, and Richard C. Lewontin, Professor of Biology and Associate Dean of the Division of the Biological Sciences at the University.

Treating Genetic Disorders

Dr. Goulian said that persons with genetic disorders "are not going to want to know the consequences. I think patients, for example, with hemophilia will not want to know the incidence of inheritance in their children. It's a painful fact in many instances and it is not something people like to face."

Dr. Goulian said the possibility of treating genetic disorders by correcting the genetic defect directly "is probably very far off in the future."

Lewontin explained that in genetic counseling "couples, either before they're married or after, who fear that they have some sort of genetic disorder in their family will come to a genetic counselor to ask what the chances are that their children will be similarly affected."

Variation Necessary to Evolution

Besides hemophilia, diabetes, sickle-cell anemia, cystic fibrosis, and phenylketonuria, which causes a severe mental defect, are among the diseases that can be inherited, they said. Beadle noted that there are now known to be several hundred traits in man that are clearly inherited in a known way.

While all three scientists agreed genetic counseling should be available to all, Beadle

(Continued on page 552)

Drinking

(Continued from page 423)

chronic alcoholic, suffered from acute alcoholism, or had been at a drinking party.

There were 61 home accident fatalities reported as due to acute poisoning by solids and liquids, and half of these were associated with drinking. Barbiturates were the culprit in nearly 75 percent of these alcohol-associated poisonings, underscoring the lack of understanding about the accentuated effects of drugs (especially barbiturates) when taken together with alcohol.

Alcohol was involved in nearly 20 percent of 87 accidental deaths at home reported as due to absorption of poisonous gases and vapors, mostly motor vehicle exhausts. Many of the victims lost their lives inhaling lethal amounts of carbon monoxide while sitting in automobiles in the family garage with motors running, as they slept or just rested from overdrinking.

Falls from stairs or steps accounted for 117 accidents in and about the home, and about 20 percent of the victims were reported to have been under the influence of alcohol.

Falling asleep with a lit cigaret, cigar or pipe is a serious hazard for the tired smoker, even when he is not under the influence of alcohol. In the insurance study, alcohol figured in about 25 percent of the 67 accidental deaths reported as due to fires and other burns among careless smokers.

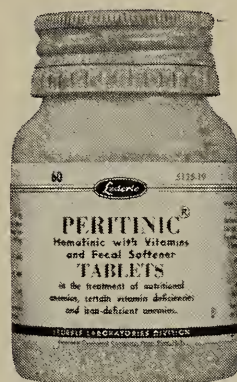
Drinking was implicated in about 15 percent of the firearm accidents at home, about 12 percent of the deaths from choking on food, about 20 percent of the drownings, and all of the deaths from freezing.

Metropolitan Life statisticians point out additional factors involved in fatal accidents at home, including environmental hazards such as faulty building design or layout, poor housekeeping, inadequate maintenance of appliances or other home equipment, and slippery weather conditions. Less tangible elements, such as personal health, attitudes, habits, fatigue and emotional tension also play a major role in home accidents. All of these factors, when combined with excessive drinking, produce greatly magnified hazards.

The Veterans Administration employs more than 76,000 women who comprise 44 per cent of the VA's work force.

for April, 1968

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Public Health Training Report

The report of the Third National Conference on Public Health Training, held Aug. 16-18 in Washington, D.C., contains 12 recommendations reflecting on health issues. According to Dr. Leonard D. Fenninger, Director of the Public Health Service Bureau of Health Manpower, "the restoration of our environment and the provision of all types of health services, community and individual, are among the most significant issues that our society faces today . . . Our resources, particularly people who are prepared to plan and deliver valuable services, to teach others, and to develop new ideas, are in very short supply."

Commenting on the specific situation in the public health field, Dr. George James, Dean of the Mount Sinai Hospital School of Medicine, New York, noted that the emphasis on public health programs is shifting and that the shift has "challenged our academic and service institutions to initiate the diversified training programs necessary to meet the needs."

The conference's recommendations focus on training mechanisms designed to provide more and better qualified people to fill health and health-related manpower gaps. They call for increases in student assistance programs, motivational programs designed to help alleviate faculty shortages, expansion of basic support of institutional training programs, extension of public health training support to qualified institutions and health disciplines not now being so supported, and a variety of other programs and projects especially intended to improve the quality and increase the quantity of manpower in the broad field of public health.

Copies of the Report of the Third National Conference on Public Health Training (Public Health Service Publication No. 1728) are available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C., 20402, at 40 cents a copy. Single copies may be obtained from the Director, Division of Allied Health Manpower, U.S. Public Health Service, 800 N. Quincy St., Arlington, Va. 22203.

Veterans Administration hospitals have pioneered in the provision of artificial legs immediately after amputation, fitting the prosthetic appliances at the amputation operation.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Malpractice Insurance Rates Zoom in Twenty States

Stiff increases in malpractice-insurance premium rates have been reported in 20 states—highlighting the need for the liability coverage sponsored by ISMS. Ranging upward from 10 per cent over 1967, the rate boosts were a whopping 48 per cent in Washington state and 50 per cent in Arizona. (In Illinois there was no across-the-board pattern; but partly because of reclassifications, rates for many Illinois physicians and surgeons rose 4 to 15 per cent last December.) The widespread hikes are blamed on rising incidence of legal actions and bigger claims. The new ISMS program, approved by the Board of Trustees in January, is intended to offer attractive premium charges, eliminate arbitrary cancellations and create a proper legal climate. As soon as the plan is available, an announcement will be made to all ISMS members by mail and through the *Illinois Medical Journal*.

* * *

Physicians Help Report Over 1,100 Child Abuses

More than 1,100 suspected violations of Illinois' Child Abuse Law have been reported to the Department of Children and Family Services since July 1, 1965, when the law took effect. Harold Donahue, the department's regional director at East St. Louis, cited the case load at the ISMS Workshop on Government Health Programs February 15 in Belleville. He predicted "an increasing number of cases . . . as physicians and hospitals continue to work with us." Aimed at preventing beatings, malnutrition and other severe damage to children's bodies and minds, the law requires medical practitioners and hospitals to report suspected infractions.

* * *

Conference Planned on Children's Aid Curbs

Faced with a dilemma resulting from tighter federal rules on aid to dependent children, Harold O. Swank and Illinois General Assemblymen were to confer in Washington, D.C., with the state's Congressional delegation. Swank, Illinois public-aid director, forecast a growth from 10,000 to 20,000 in the number of dependent youngsters exceeding the federal matching funds for the state. According to the present outlook, either the state must make up the cost difference, or the allocation per child must be cut. Another financial blow, he said, was a recent federal court ruling that upset Illinois' one-year residence requirement for ADC.

* * *

New Help in Offing for State's Alcoholics

Alcoholism—now the nation's Number 3 public-health problem—affects an estimated 450,000 Illinoisans, including

250,000 metropolitan Chicagoans, says a report of the Chicago Council on Alcoholism. A recent Presidential message to Congress asked a fiscal 1969 appropriation of \$13,400,000 for Health, Education and Welfare programs on the causes and treatment of alcoholism. The funds would go chiefly to community mental-health centers.

* * *

State's Economic Growth May Hike Medical Needs

Illinois' economic growth—while a wonderful phenomenon—may pose an added challenge to the state's overburdened medical resources. Employment reached 4,717,300 in 1967, exceeding the previous year's figure by 1.8 per cent, reported the Illinois State Chamber of Commerce. New and expanded plants totaled 587 last year and will create some 43,000 jobs.

—By DON B. FREEMAN

AMA Booklet on 'Household Hands' Available

"Household hands," a problem confronting every woman, can be avoided or improved by taking proper precautions, an informative, new, six-page AMA pamphlet, "Housewife and Her Hands," points out.

Prepared by Elizabeth W. Rauschkolb, M.D., for the AMA Committee on Cutaneous Health and Cosmetics, the publication discusses the various skin irritation

problems which can plague women and gives practical tips on how to avoid them or keep skin eruptions from getting worse. Principal topics covered are actions and reactions, allergic contact dermatitis, injuries and infections and a short story on suds.

Available from the AMA Order Department, single copies are 10 cents. When ordered in quantities of 100-999, it is offered at two cents a copy.

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MEETING MEMOS

Apr. 22-25—The Annual Convention of the Industrial Medical Association and the American Association of Industrial Nurses will be held jointly as part of the American Industrial Health Conference at the Hilton Hotel, San Francisco. This medical-nursing conference will bring together approximately 2,500 persons engaged in industrial health activities.

Apr. 23-27—The 18th Annual Meeting of SAMA is scheduled to be held in Detroit. Wayne State University School of Medicine, celebrating its centennial, is to be host.

Apr. 24-25—"Laboratory Aspects of Hematology" is the subject of a postgraduate course being offered by the Cleveland Clinic Education Foundation. Registration is \$30. Five guest speakers and 11 faculty members will present the varied program.

Apr. 25—The fourth annual Post-Graduate Symposium on Rheumatic Diseases will be held in the Rankin Amphitheater, Louisville General Hospital, University of Louisville Medical Center, Kentucky. The conference will be devoted to the systemic disorders involving connective tissue or "collagen" diseases.

Apr. 29-30—The Fifth National AMA Congress on Environmental Health Problems will be held in Chicago. Attention will be focused on the goals and recommendations made in a special HEW report, called "A Strategy for a Liveable Environment" of the Linton Report.

May 1-3—The New York University School of Medicine will conduct a symposium on "Virologic Approaches to Cutaneous Diseases." Recent advances in basic virology, virus replication, electromicroscopic investigations, interferon and oncogenic viruses, will be discussed.

May 2-4—The American College of Clinical Pharmacology and Chemotherapy will hold its fifth Annual Meeting at the Claridge Hotel, Atlantic City, N.J.

May 4-13—A post-graduate seminar in rhinoplasty and otoplasty will be presented at Mt. Sinai Hospital, New York under the direction of Irving B. Goldman, M.D. It is under the sponsorship of the American Academy of Facial Plastic and Reconstructive Surgery,

Inc. It is designed particularly for teaching specialists in head and neck plastic surgery.

May 13-24—A two-week course in Cancer Chemotherapy is offered at the University of Texas M.D. Anderson Hospital and Tumor Institute, Houston. Approaches in current clinical drug use and the management of the cancer patient will be reviewed as well as new drug availability.

May 13-16—"Pesticides and Public Health" is the title of a course being offered at the National Communicable Disease Center, Atlanta, Ga.

May 19-20—Current Concepts of the Basic Actions of Dextrans and Their Clinical Application in the Cardiovascular and Related Fields is the title of a two-day program scheduled for the Flagship Hotel, Galveston Island, Tex. It is co-sponsored by the University of Texas, University of Minnesota and Georgia Institute of Technology Medical Schools and the Texas Heart Association. This is the first International Symposium on this topic and researchers from Europe and the United States will participate.

May 19-22—"Total Care" is the theme of the 128th Annual Convention of the Illinois State Medical Society. It will be held in the Sherman House, Chicago. All Illinois physicians are encouraged to attend.

New Products

(Continued from page 526)

manufactured as a 0.1 percent cream in 5 and 15-gram tubes.

Betamethasone 17-valerate was chosen for clinical trial from among 50 new, unmarketed corticosteroids on the basis of vasoconstrictor bioassay activity, high activity being demonstrated in vasoconstriction tests performed with alcoholic solutions of betamethasone 17-valerate.

Clinical use studies of Valisone in 872 patients with corticosteroid-responsive dermatoses produced a response described as good or excellent in 88 percent, even though the cream was used without occlusion in three-fourths of the patients.

The choice for clinical trial by vasoconstrictor bioassay of over 50 newly synthesized compounds, beta-methasone 17-valerate is a new steroid ester. In its marketed

(Continued on page 548)

COOK COUNTY

Graduate School of Medicine CONTINUING EDUCATION COURSES STARTING DATES—1968

SPECIALTY REVIEW COURSE IN OB-GYN, May 6
SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 13
SPECIALTY REVIEW COURSE IN MEDICINE, Part II, June 3
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
PROCTOSCOPY & VARICOSE VEINS, One Week, May 6
FLUIDS & ELECTROLYTES, One Week, April 22
SURGERY OF THE HAND, One Week, May 6
PELVIC SURGERY, One Week, April 29
DIAGNOSTIC RADIOLOGY, One Week, April 22
RADIOISOTOPES, One or Two Weeks, First Monday each month
BASIC INTERNAL MEDICINE, One Week, April 22
GENERAL PRACTICE REVIEW, One Week, May 6
CLINICAL NEUROLOGY, One Week, April 29
DERMATOLOGY, One Week, April 29
ADVANCES IN MEDICINE, One Week, May 13
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

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330-8/6135

Share Your Medical Journals With Colleagues Overseas

The doctors of the U. S. A. are being asked to send their medical journals—after they have read them—to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature, but either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals. We can supply you with the name, address and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, (particularly specialty journals), which you will mail direct to your overseas colleague.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of the World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your co-operation in this program will be greatly appreciated and your contact with these colleagues in other countries, we can assure you, will prove very gratifying. If you wish to participate in this program, send your name, address, and titles of journals you will contribute to DOCTOR-TO-DOCTOR PROGRAM, Ada Chree Reid, M.D., Director, c/o The World Medical Association, Inc., 10 Columbus Circle, New York, N.Y. 10019.

New Products

(Continued from page 547)

form, Valisone Cream, it rapidly suppresses inflammatory responses in the skin, controlling pruritis, erythema, and swelling.

Specific conditions treated effectively with Valisone include psoriasis, eczema, hand eczema, seborrheic dermatitis, contact dermatitis, atopic dermatitis, neurodermatitis, lichen planus and lichen simple chronicus.

In allergic or contact dermatitis, Valisone provides excellent symptomatic relief until the contactant or allergen is identified and removed from the patient's environment.

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Efficacy of Valisone was also demon-

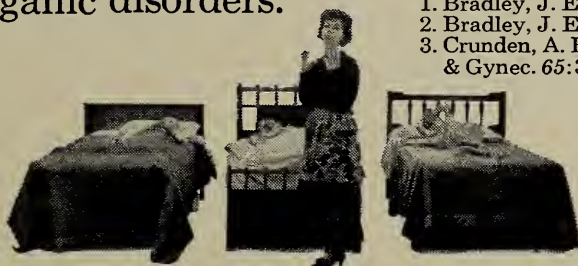
(Continued on page 552)



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1. Bradley, J. E., *et al.*: J. Pediat. 38:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. 20:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



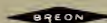
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OBITUARIES

***Dr. Elmer N. Ascherman**, 72, an industrial surgeon who had been a Chicago physician for 48 years, died Feb. 23.

***Dr. Hugh P. Dorsey**, River Forest, died Feb. 22. He was a staff member at St. Anne's Hospital for more than 50 years and was a member of the Fifty-Year Club of ISMS.

***Dr. Frank J. Fara Sr.**, Riverside, died Feb. 16 at the age of 59. He was a member of the American College of Surgeons, the American College of Obstetricians and Gynecologists and the American Board of Obstetricians and Gynecologists.

***Dr. Howard I. Ganser**, Evanston, died Feb. 28 at the age of 53. He was a psychiatrist on the staff of Mount Sinai Hospital, Cook County Hospital mental health clinic, and a fellow of the American Board of Obstetrics and Gynecology.

Dr. Dennis J. Kirlin, River Grove, died Feb. 17 at the age of 83. He had practiced medicine for 40 years before retiring in 1957.

Dr. Frank M. Laurenzana, 62, died Mar. 8 at St. Elizabeth Hospital, Chicago, where he was a member of the staff for 30 years.

***Dr. Roland P. Mackey**, former president of the American Neurological Association, died Feb. 21 at the age of 67. He was professor of neurology at Northwestern University, senior attending neurologist at Chicago Wesley Memorial Hospital, consulting neurologist at Hines Veterans Hospital, and of the Veterans Administration Research Hospital.

***Dr. H. Petrie Mosby**, Rockford, died Feb. 9 at the age of 77. He was a member of the Winnebago County Medical Society.

***Dr. Raleigh C. Oldfield**, Oak Park, died Feb. 28 at the age of 75. He was past president of the Illinois State Medical Society, a member of the Board of Trustees, Fifty-Year Club, an alternate delegate to the American Medical Association.

***Dr. Lawrence Donat Ryan**, Chicago, died Feb. 25 at the age of 67. He was on the staff of St. Joseph Hospital and was a diplomat of the International College of Surgeons. **Dr. Charles K. Stulik**, a specialist in pediatrics and internal medicine for more than 50 years, died Feb. 1 at the age of 78, in Presbyterian-St. Luke's Hospital, of which he had been a staff member for 43 years. He also was on the staff of Cook County Hospital for 20 years.

Dr. William B. Talbot, 71, a member of the

Joint Commission on Hospital Accreditation, died Feb. 24 in Chicago.

***Dr. Edward William White**, 82, vice president of the Illinois Masonic Hospital board of trustees for 25 years, died Mar. 4. He was also a staff member and a former chief of the neurology department at the hospital.

**Member of Illinois State Medical Society*

How Long Do Presidents Live?

(Continued from page 420)

longer than might have been expected at the time of their inaugurations. There were 13 Presidents following Lincoln who died natural deaths. They lived an average of only 66.6 years, or almost five years less than expected. When the four assassinated Presidents (all of whom held office after 1860) are included, the average duration of life for the 17 postbellum Presidents is reduced to 63.4 years, or almost eight years less than expected.

Although the difference in longevity between the two periods is not as marked for Vice Presidents as for Presidents, the longevity of the former after 1860 has been definitely more favorable. Those Vice Presidents who came before Lincoln fell short of their life expectation to a greater extent (about 4 years) than those who came after (about 1.8 years). The Vice Presidents from Burr to Breckinridge lived an average of 67.4 years, but those from Hamlin on lived an average of 72.2 years. On the other hand, the pattern of longevity of the unsuccessful candidates before and after 1860 parallels that of the Presidents. The deceased candidates from Pinckney to Fremont lived an average of 72.3 years, or around .3 of a year more than expected, but those from Douglas to the present lived an average of 68.5 years, or some 4.0 less than expected.

Our longest-lived Presidents so far have been John Adams and Herbert Hoover, each of whom died at 90. Adams, 61 when he took office, lived about 16 years beyond his expectation of life at that time. Hoover took office at 54 and lived around 17 years beyond such expectation of life. Our shortest-lived Presidents were John F. Kennedy, who died at age 46, and James A. Garfield, at 49, both men at the hands of assassins.

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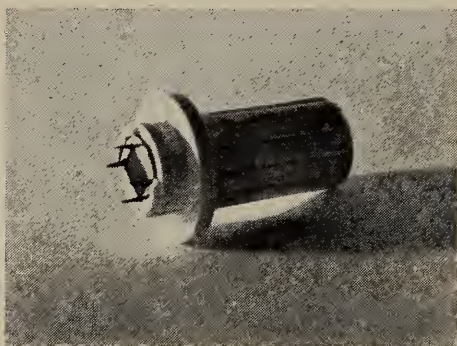


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(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



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Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A-H-ROBINS

Genetic Counseling

(Continued from page 542)

stressed, "I think there is a really serious doubt as to how far with our present knowledge we would want to go in trying to control" the composition of society through compulsory compliance to a genetic counselor's advice.

"You can't have evolution unless you have variation," Beadle said. "You don't change unless you have a variety."

Regulate Intelligence?

Asked whether society should forbid individuals to reproduce who might have genetic defects, Beadle said, "You're getting into a really difficult social question. Making it even more difficult, what other kinds of characteristics would you have society regulate? General intelligence, for example, may be in some respects more important than specific diseases. This raises enormously difficult questions. In that sense, you add to the genetic diversity and the cultural diversity with an inability to tell the difference between the two in most cases."

Lewontin pointed out that while most medical schools have genetic counselors, most people do not know the service exists. But, Lewontin added, adherence should not be made compulsory. "One has no right to impose this on people, unless there is some clear and present danger to society as a whole."

"The University of Chicago Round Table" is produced for public television by WTTW in co-operation with the University. The moderator is Kenneth J. Northcott, Professor of Older German literature and Dean of Students in the Division of the Humanities at the University.

New Products

(Continued from page 548)

strated in controlled and clinical use studies:

Writing in *Pennsylvania Medicine*, Raymond W. Goldblum, M.D.—a dermatologist and staff member at Montefiore and Presbyterian University hospitals in Pittsburgh, Pa.—reported good to excellent results in 4 of 7 patients with psoriasis; 22 of 24 with atopic eczema; 16 of 17 with neurodermatitis; 6 of 7 with seborrheic dermatitis; and all patients with contact dermatitis or nummular eczema.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 5

May, 1968

Just Twenty Years Ago

The Blue Shield Plan of Illinois Medical Service was founded at the end of 1947 as Chicago Medical Service to serve the people of Cook County and began operating in April 1948—just twenty years ago. The Plan was sponsored by and is under the direction of physicians and offers its members the opportunity to budget in advance for part of the expense of their professional care.

In answer to increasing demands to extend Blue Shield to other Illinois Counties, the name was changed to Illinois Medical Service late in 1949. The Blue Shield Plan of Illinois Medical Service now does business in 96 Illinois Counties and has the approval of the Department of Insurance of the State of Illinois.

In August 1954, Blue Shield's General Certificate was revised by adding a number of increased allowances and a broader scope of benefits. About a year later, in answer to additional demands by member groups for increased benefits, Blue Shield offered another Blue Shield certificate. Since then, Blue Shield has made available to its subscribers a larger variety of certificates ranging from a limited scope of benefits to a broader scope; from smaller indemnity allowances to allowances paying physicians' usual charges within the customary range.

The growth of the Plan over the years has been outstanding. In 1967 enrollment reached an all time high of over 2¼ million members which was achieved when 524 new organizations enrolled their employees in one of our programs.

During the past year over 26 million dollars was paid by us for over 600,000 professional services received by subscribers and their family members.

As fiscal intermediary of Part B of Medicare, our Blue Shield Plan has handled nearly 499,000 claims of people over 65 in the greater Chicago area.

The Plan is managed by a Board of unsalaried Trustees representing different sections of the geographic areas served by the Plan. The Board has the power to adopt and amend the bylaws governing the conduct of the Plan's business and the majority of the Trustees must always be physicians licensed in Illinois to practice medicine in all its branches.

Health Improvement Association Enrolls in Usual and Customary

Effective July 1, the H.I.A.'s 200,000 members and their dependents will be protected by Blue Shield's Usual and Customary program.

H.I.A. members have been notified of their new protection described in a special brochure we have prepared for the group.

John C. Troxel, M.D., Senior Vice President, Medical Director, Blue Cross Blue Shield, has written all County Medical Societies Secretaries and Presidents informing them of this newest and largest group to enroll its members and has attached a copy of the brochure for their information.

We welcome the opportunity to meet with you or your office assistant to discuss this program in further detail and invite you to contact us for additional information.

Blue Shield Meetings for Medical Assistants

The annual Blue Shield series of dinner meetings for medical assistants got off to a good start April 17 at the Freeport Country Club, Freeport, Illinois.

Thirteen meetings for medical assistants outside the Metropolitan Chicago area (Cook, Kane, Lake, Will, DuPage, and McHenry Counties) will be held between April 17 and June 27. Following dinner, staff members of Blue Shield will tell about our new Usual and Customary program and how it works for the doctor and member. We will answer questions relative to our Major Medical, Blue Shield, and our new Blue Cross-Blue Shield 65 program.

Medical assistants have been mailed invitations to this important meeting and are urged to return their reservations.

The remaining meetings are scheduled at 6:30 P.M. Thursday, May 16, Hotel Wolford, Danville; Wednesday, June 5, Holiday Inn, Quincy; Thursday, June 6, Sangamo Club, Springfield; Thursday, June 13, Ramada Inn, Peoria; Wednesday, June 19, Holiday Inn, Effingham; Wednesday, June 26, The Plantation, Moline; Thursday, June 27, Soangetaha Country Club, Galesburg.

ASK BLUE SHIELD

● ● ● ABOUT MEDICARE

Q I have a Medicare patient in a non-participating extended care facility. Will her current spell of illness end after 60 days, (and renew her hospital benefits) or is the time she is in the non-participating facility a continuation of her present spell of illness?

A If her facility provides skilled nursing care (rather than just custodial care), nonparticipation in Medicare is irrelevant. The spell of illness ends 60 days after the patient is discharged from a hospital or an extended care facility that provides skilled nursing care.

Q One of my patients has arteriosclerotic heart disease. I visit her periodically in a nursing home where she is receiving custodial care. Will Medicare pay for my visits?

A Yes, charges for professional services are allowable if they are necessary to a treatment of illness or injury. However, custodial care in the facility is not a covered expense.

Q I am an orthopedist and at times take my portable x-ray unit to elderly patients' homes to see how fractures are healing. Is this service paid for by Medicare?

A Yes. Diagnostic x-rays taken in patients' homes may be covered under Part B if a physician takes them, or if they are taken on his written order by a qualified provider of these services who meet certain health and safety requirements.

Q I have a Medicare patient whom I placed in a nursing home following a hospital stay. After he returned home he had to be readmitted to the nursing home. Will Medicare pay for the second admission?

A If the individual leaves the participating extended care facility and is readmitted within 14 days, it would be considered a benefit in the same spell of illness.

Q Is there any way to determine whether a Medicare patient has subscribed to Part B without waiting for the claim to be processed?

A Ask the patient to produce his Medicare card. It will show his name, whether he is entitled to Hospital Insurance, Medical Insurance, and the effective dates.

Q What information do you require when I bill my Medicare patients for hospital visits?

A It is necessary for us to know the date of hospitalization, the dates of each visit, and the charge for each visit. This information should be included on the Request for Payment Form 1490 if you accept an assignment or if you assist your patient in completing the form. Otherwise it should be included on the itemized bill you give your patient.

Q Will Medicare pay for the charge of non-self-administerable drugs, such as allergy serum, which the patient purchases and brings to my office for an injection?

A To be paid by Medicare, the non-self-administerable drug must be furnished by the physician who administers it and includes it in his patients bill. Also, insulin injections received regularly by a diabetic to maintain the proper blood sugar level are commonly self-administered and are therefore excluded from coverage.

Q Will Medicare pay for refractions?

A No. All refractions performed during any eye examination are excluded from coverage whether they are performed by ophthalmologists, other physicians or optometrists.

Q If I accept an assignment, do I establish a procedure that must be followed in the future for all my Medicare patients?

A No. You may decide each situation separately. The fact that you do accept an assignment from one patient does not obligate you to continue that arrangement even with the same patient. Matter of payment for your services is between you and your patient.

Q I accept assignments from my patients and also give them an itemized bill. Should I have the patient sign the assignment claims?

A It is necessary that we have the patient's signature on all assigned claims unless a blanket Request for Payment form 1490 has been submitted for the same illness. When you accept an assignment and have your patient sign the form 1490, and at the same time give him an itemized bill, you increase the possibility of duplicate payment being made for the same service. If your patient submits the itemized bill for payment and we receive it before we receive your assigned form 1490, we would make payment to your patient. To help avoid this possibility, include on your itemized statement that you have accepted assignment and have billed Medicare.

Our Government Contracts Division

reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during March for over 81,500 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding \$4,900,000. For the year 1968 through March, payments have been made on over 201,000 cases for an amount exceeding \$11,400,000.

The number of cases processed in March under Part A exceeded 76,000 with payments to providers amounting to more than \$19,000,000. For the year 1968 through March, over 213,000 cases have been processed and payments to providers have exceeded \$54,605,000.

NOTICE

To help speed payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

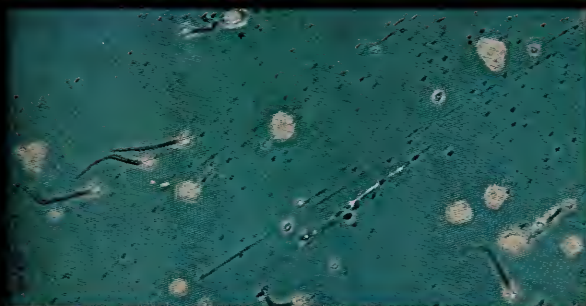
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

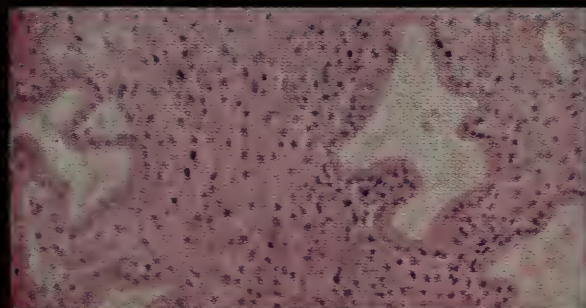
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

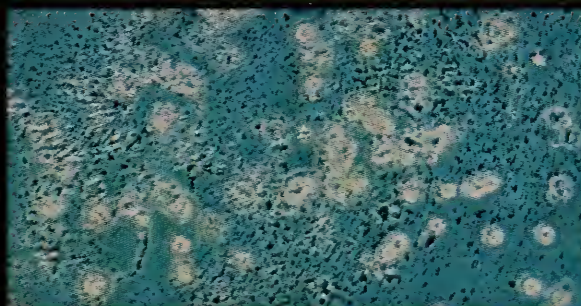


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

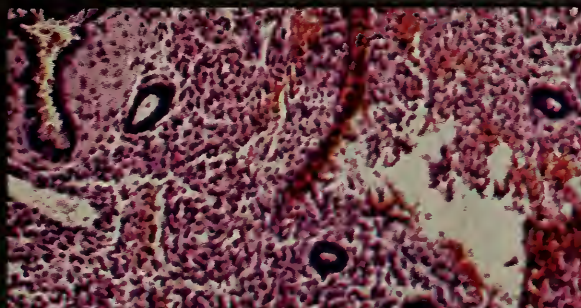
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



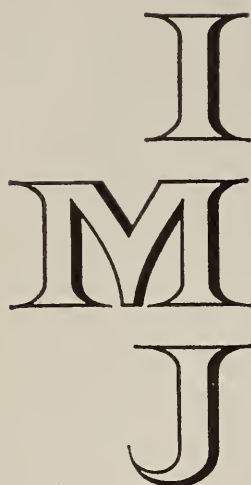
Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl-1[®]
(norethindrone 1mg. & mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



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Abstracts of Board Actions

March 23-24, 1968

UTILIZATION REVIEW PROBLEMS

To help resolve increasing problems of utilization review in hospitals, the Illinois State Medical Society and the Illinois Hospital Association will co-sponsor a series of programs on utilization review function. The programs will be conducted in 10 different locations starting in June.

SELECTED MATERNAL DEATH STUDIES TO BE PUBLISHED

On recommendation of the Committee on Maternal Welfare, the ISMS Board of Trustees has approved publication of hypothetical case histories of illustrative obstetrical problems presenting particular morbid situations. The committee has carefully outlined procedures to be taken to assure anonymity and yet present cases having educational value.

BOARD DENIES REHABILITATION COMMITTEE PLEA

On learning that a significant portion of federal funds were not available for patient use in Illinois because the state had not appropriated sufficient money to match that supplied by the national government, the Committee on Rehabilitation supported by the Council on Scientific Services, requested that the Illinois legislature be encouraged to provide necessary funds to make the release of monies possible. This request was disapproved by the ISMS Board of Trustees and Dr. Joseph Skom, Chairman of the Council on Scientific Services, indicated he would ask Dr. Henry Betts, Medical Director of the Chicago Rehabilitation Institute and Chairman of the ISMS Committee on Rehabilitation Services, to appear at a future meeting of the Board to present his committee's recommendation in person so that pertinent supporting data could be available.

PRESIDENT TRAVELS 28,700 MILES

Dr. Newton DuPuy reported to the Board of Trustees that by mid-March his journeys as president of the Illinois State Medical Society had resulted in 94 days out of his office and some 28,700 miles of travel.

DATA PROCESSING SYSTEM PROVIDES ADDRESS BREAKDOWN

The ISMS Board of Trustees has approved a Journal Committee recommendation that names and addresses of Illinois physicians be made available to Journal advertisers for a small service charge. Non-advertisers would be charged 50% more than advertisers for this service. A breakdown of physicians by various categories such as age, speciality and area of practice is now possible through the Society's new data processing system.

PRECEPTORSHIP PROGRAM GIVEN FINANCIAL SUPPORT

The Board of Trustees has approved a Finance Committee recommendation that a contribution of \$750 be made to carry the ISMS Pilot Preceptorship Program in DuPage County into the current year.

MEETINGS WITH DIVISION DIRECTORS ORDERED

By official action the Board has instructed the Executive Committee to meet at least twice a year with ISMS division directors and to keep informed of all activities at headquarters. The action followed a recommendation from an Ad Hoc Committee to Study Headquarters Office.

FINANCE COMMITTEE RECOMMENDATIONS ON EXPENDITURES

Other recommendations of the Ad Hoc Committee which the Board approved are:

1. All contracts involving over \$500 should require a review of a committee assigned for this work, and should be signed by the committee before being activated.
2. That a local (Chicago) physician from the Board be appointed to act as assistant treasurer and provide supervision of expenditures.

COOPERATION ON STATE LICENSURE

By official action, the Board has adopted the following statement on state licensure:

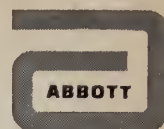
"In order to insure that all physicians licensed to practice medicine and surgery in all of its branches are at all times fully competent, it is recommended that each county medical society formulate a method by which it can evaluate physicians whose clinical judgment may be impaired by the nature of their physical or emotional condition. The evaluation report, including circumstances and history of each case, should be directed to the office of the Executive Administrator of the Illinois State Medical Society"

REVISED MENTAL HEALTH CODE MAILED TO ISMS MEMBERS

Substantial revision to the Illinois Mental Health Code will affect the practice of nearly every physician. In addition, new forms have been devised.

To facilitate the handling of the new forms and to make available copies of the annotated and indexed new Code, the Illinois State Medical Society has arranged to have these mailed to all members of ISMS. In booklet arrangement, the package should be of significant interest and furnish excellent guidelines for the practicing physician.

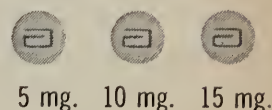
That's why Abbott offers you a pill plus a program.



The Product

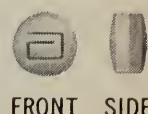
*For smooth appetite
control plus mood
elevation*

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

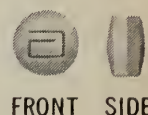


*For patients who can't
take plain amphetamine*

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



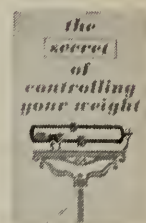
DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



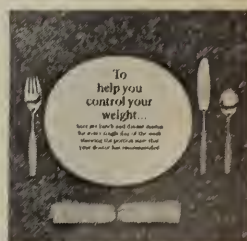
Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

*Please see Brief Summary
on next page.*

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

Awareness of Hazards Cuts Down Use of LSD

Broader awareness of dangerous side effects from LSD is contributing to an apparent decline in the use of the drug, according to Dr. Jerome Levine, a National Institute of Mental Health scientist.

Reports from hospital emergency services show that "there are definite dangers that attend the medically unsupervised use of the drug," Dr. Levine, an authority on LSD, told a recent meeting of the American College of Neuropsychopharmacology in Puerto Rico.

The seriousness of the side effects and the frequency with which they occur may partly explain the drug's wilting popularity.

Dr. Levine said the most common hazards are:

1) **The panic reaction.** This occurs when the drug taker realizes that he cannot control the unique experience that the drug has triggered in him. He desperately wants to end the drug's effect because he "cannot stand it," and fears he is losing his mind.

2) **A paranoid reaction.** During the drug session, the individual becomes suspicious that someone is trying to poison him or to control his mind. These feelings usually last about 72 hours after the drug wears off.

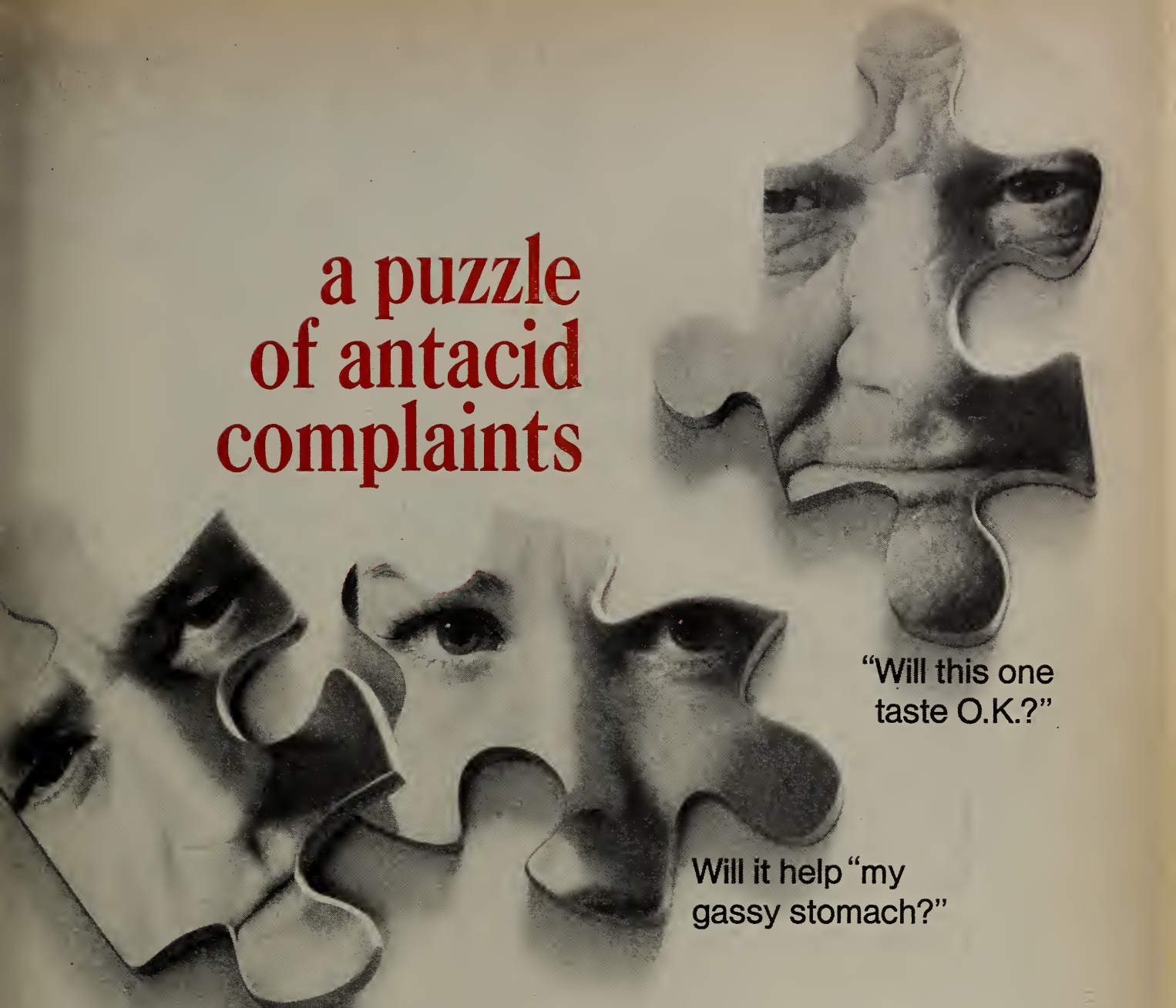
3) **A recurrence of the drug experience.** Days or even months after stopping the drug, the person unaccountably may repeat his drug-induced reaction. The recurrence frequently takes place during some stressful situation, and the person may fear he is going insane.

4) **Loss of judgment.** Judgment becomes impaired during LSD use. "Individuals have been known to walk out of windows because of the conviction that they can fly. Others have reported feelings of invincibility and are willing to do extremely dangerous things because they believe that if their physical body dies, their spirit will live on," Dr. Levine said.

Dr. Levine said he believed the drug will continue to be a useful biomedical research tool, and studies evaluating its use for treatment of alcoholism and psychoneurosis will continue. But he observed that even if LSD turns out to be useful in treating patients, it probably will not be used on a very wide scale.

(Continued on page 666)

a puzzle of antacid complaints



"Will this one
taste O.K.?"

Will it help "my
gassy stomach?"

"Will it stop the pain?"

Mylanta[®]

aluminum and magnesium hydroxide plus simethicone

a solution to peptic ulcer distress

Effective neutralization—

with the two most widely prescribed antacids:
aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—

with the proven¹ defoaming action of simethicone.

Prolonged acceptance confirmed—

in 87.5% of 104 patients after a total of 20,459
documented days of therapy.²

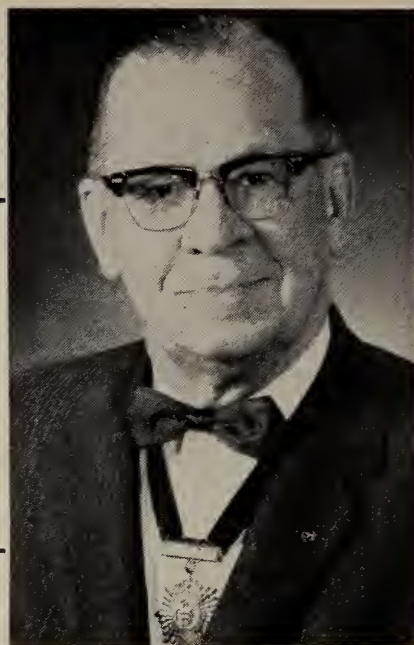
Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

The president's page



Newton DuPuy, M.D.

Sooner or later everyone must sit down to a banquet of consequences and so I must rest with what has appeared on this page this year. In the words of Alexander Pope, "Authors are partial to their wit, 'tis true; but are not critics to their judgment, too?" My errors of judgment and my mistakes would have been many more had it not been for the editing of Mr. Perry Smithers who has done his best to preserve me. AND so farewell! Henry Austin Dobson aptly states "Time goes, you say? Ah, no! Alas, time stays WE go." As I bow out on this page, I leave you these thoughts to answer our critics in these times of recurring crises. A physician's business is with people. If you would consult the Oxford Dictionary you would find offered among the definitions of the word PHYSICIAN, "One who cures moral, spiritual, or political maladies." Plato, the philosopher, said, and I quote, "No physician insofar as he is a physician, considers his own good in what he prescribes, but the good of his patients; for a true physician is also a ruler having the human body as a subject, and is not a mere money maker." Let us live up to the physician's image.

Lord, let me carry where I go, some little joy to all I know. Let these into my life be wrought—a little faith, a little thought, a little mirth, a little grace, to glorify the commonplace; Lord, let some little splendour shine to mark this earthly course of mine.

Newton DuPuy, M.D.

The Health Team of '68

By A. NICHOLS TAYLOR, PH.D./CHICAGO

Health service is a personal service provided by people to people and, although we may correctly speak of the health service industry, human resources and human concerns remain the essential basic ingredients of this service. The health service industry is the nation's fastest growing employment field. Almost 300,000 physicians with their office and emergency care facilities, over 2½ million allied or related health professional and technical personnel, almost 8,000 hospitals with 1¾ million beds, several thousand nursing homes, rehabilitation centers and day-care facilities are directly involved in the minute by minute provision of health care to the American people. With an ever-increasing awareness of the public regarding medicine in all of its aspects—preventive, diagnostic, and curative—and with an increasing demand for health services, it is proper that all segments of society give attention to changing social philosophies and expectations as to the quantity and quality of health services, the best or-

ganization for the delivery of these services, and the education and efficient utilization of manpower to meet these health needs.

Health Manpower Shortages

With the rising capacity of medicine to provide a satisfying array of services, the lowering of financial barriers to health services, and the growing acceptance of a public responsibility to assure that all people will have adequate medical service, the needs and demand for medical care continue to outstrip the available health manpower to supply these services. Many individuals as well as private and governmental agencies have been and are struggling with approaches to the measurement of health manpower shortages. In reality, no one figure can express the total need. Even if it were possible to envision an ideal health service staffing for a community, a state, or a nation, the continuing development of new knowledge and techniques, new patterns of service, and new methods of payment for

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these services are constantly changing the needs, both for numbers and varieties of health workers.

It has become almost trite to refer to the stunning growth of our population and the related expansion of our economy. Not only are there many more of us for whom health services must be provided, but many of these people are in those age groups, the very young and the old, which require the greatest amount of service. The progressive rise in the levels of education and personal income have not only made us more aware of what health services are available, but have translated this awareness into effective demands for those services, improved transportation, urbanization, health insurance programs both private and governmental, and the increasing effectiveness of diagnostic and therapeutic procedures only serve to accentuate these demands. The annual expenditure on health services in this country increased from \$13 billion in 1950 and \$27 billion in 1960, to almost \$40 billion last year. Private spending for personal health care was more than \$26 billion, or about 6 percent of personal consumption expenditures. It is obvious that if success is to be maintained and the health care needs of the people adequately met, there must be properly trained and educated suppliers of health services. Further, they must be available in sufficient numbers, working under such conditions, and with the necessary equipment and facilities that their services can be rendered effectively, efficiently, and at a reasonable cost to the public.

New Divisions of Labor

As the knowledge and opportunities of medical science are growing and changing, so are the talents and skills of the people who provide health services. New knowledge creates the need for new technologies, and with the development of new bodies of knowledge come new professions. In their wake arise new divisions of labor.

Today, no one or two individuals alone are capable of acquiring the breadth of knowledge to deliver the range of potential health services. Many types of skills must be drawn on to provide comprehensive health care. The most indispensable person in the health field is the physician. Together with the patient, he makes up the doctor-patient relationship which is so fundamental to everything that is done in health care. How-

ever, societal demands and scientific advances are forcing the physician more and more into the role of a manager—a role for which he has not been specifically trained and which is new to his tradition. As the managerial function increases, so does the physician's dependence upon others to work with and assist him in the delivery of health care. It is then paramount that each member of his supportive team perform to specifications, and that their several skills interlock in the right way at the right time. The training and education of supportive personnel, the related health professions and services are, therefore, of more than passing interest to the physician. Their competence has a vital role in his every activity. As medicine continues to advance and demands increase, this dependence can only multiply.

Size of Team Enlarged

The concept of the health team is not new, only the size of the team is being enlarged. The happy twosome of the doctor-nurse has today been augmented with a cadre of some 14 additional professional and technical health personnel. This team has not been assembled without problems. The problems are found both in the availability of personnel, and in the manner in which they are utilized. This unfortunate situation is in part the result of haphazard development of educational programs for health workers at all levels.

The allied or related health occupations include a broad range—perhaps every group beyond medicine and dentistry. We speak often of professional and technical fields, but the terms tend to defy definition. What is a health profession? For some purposes it can be defined as one for which preparation is at least the baccalaureate level, a point at which there is presumably some mastery of both the theoretical and technical aspects of the body of knowledge of a professional area, and at which the student has gained a broad general education in the humanities and social sciences as well as preparation in the biomedical sciences. But for some fields the professional organization and licensing laws give equal recognition to two- or three- or four-year post-high school preparation.

Technologists and Technicians

For some fields the word "technologist" is used to mean a person with baccalaureate level preparation, and "technician" one- or

two-year preparation. Obviously there are exceptions to these neat arrangements and there is not general agreement as to the educational qualifications and responsibilities which differentiate the two. In a similar fashion the word "therapist" may denote a wide range of educational levels as does the word "nurse".

Related health personnel are trained in a wide variety of situations ranging from a highly structured university curriculum to an on-the-job or bench training. For the most part, the training is in isolated curriculums and at some magic date in the future the physician, the nurse, the therapists, the technologists and all of the other members of the health team are to gather about the patient and suddenly begin functioning with effective, efficient health care togetherness.

Educational Patterns

The Chicago Medical School has accepted the challenge of our day to do its part in making comprehensive health services available for all people by providing an educational structure of a magnitude sufficient to supply a significant number of well-prepared personnel, and of an educational pattern that will promote the development of smooth-functioning health teams. For over fifty years, medical graduates of CMS have taken their places in the respected community of medicine. In December of 1966, The Chicago Medical School announced plans to become one of the first universities of the health sciences in the country, thereby committing itself to the development and training of health personnel of all categories. The appointment in 1967 of the Dean of the School of Related Health Sciences was another tangible expression of this commitment.

Planning for education in the related health occupations must begin with certain assumptions:

1. The demand for health services will continue to grow and will, for some time to come, exceed our capacity to produce the quantity as well as the quality of personnel needed.
2. Educational programs must be so structured as to provide a sound general base on which career development can be built with a minimum of wasted time and effort.
3. The present pattern of organization

and delivery of health services is not static and room must be left for innovation and experimentation in the delivery of health care, types of personnel and their educational preparation.

4. The education of health personnel must be a joint venture of educational institutions, health care institutions and health practitioner groups; clinical exposure of students, albeit essential, must provide the requisite value.
5. Teachers should have preparation in teaching and have knowledge as well as skills to impart to the students.
6. There must be regular planning for educational priorities—locally, regionally and nationally.

In the School of Related Health Sciences it will be possible to group a large number of health curriculums. Some of these are in existence now and have a long record of effectively preparing health manpower. This School of Medical Technology is a prime example. Other programs will be added. In this approach the individual curriculums gain status and strength. Programs which are inherently related are thus placed in an environment where constant interaction is possible. Attention will be given to minimizing duplications in such areas as administration, faculty and facilities. More importantly, individuals who will later work together as a health team, will learn together.

In addition to enlarging the educational opportunities for the now recognized related health professions and services, experimentation and development of educational programs for new types of health workers are essential. Health workers are needed to perform a variety of duties which are supportive of and complimentary to existing health occupations. It is important that certain of these training programs and occupations be oriented to provide upward and lateral mobility for individuals who might otherwise be locked in "dead end jobs". Job satisfaction and an opportunity to progress must be an integral part of any training program in the health field. The CMS School of Related Health Sciences accepts gladly the opportunity to work cooperatively with community colleges, senior colleges, vocational high schools and in-service hospital schools to the end that an increasing number of trained, responsible members can effectively assume their respective roles on the health team that is in truth a team.



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**SURGICAL
GRAND
ROUNDS**

Case Presentation:

Gallstone Ileus

EDITED BY JOHN M. BEAL, M.D.

Northwestern University Medical Center

Surgical Grand Rounds are held weekly on Saturday at 8 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on Oct. 14, 1967.

DR. CLARK FITZMORRIS: An 80-year-old white man was admitted July 21, 1967, with the chief complaint of epigastric pain. Twenty-four hours earlier he had sudden onset of epigastric pain two hours after dinner, which was relieved slightly by vomiting. He vomited bile stained material at about 1:30 a.m. He awoke with severe epigastric pain and was admitted to the hospital. His past history revealed two episodes of right upper abdominal pain, radiating to the scapula, which occurred widely separated during the past five years. He was said to have diverticulitis 10 years ago for which a bland diet was prescribed but not taken. He denied jaundice, chills, fever, hematemesis, bright red blood, or melena per rectum. He did not drink alcoholic beverages.

Blood pressure of 130/60, pulse 60 and regular, oral temperature was 98.6°. His abdomen was flat and there was epigastric and left lower quadrant tenderness. Rebound tenderness was not present and bowel sounds were normal. Abdominal masses or organomegaly were not detected. A large prostate, a large right inguinal hernia and a small left inguinal hernia were present. Urinalysis, blood urea nitrogen, fasting blood sugar, calcium phosphorus, and uric acid were normal. Serum bilirubin, alkaline phosphatase and serum proteins were also normal. A chest x-ray was unremarkable.

White blood count was 13,800 with a normal differential. Several radiologic studies were conducted.

DR. ABRAM CANNON: The admission abdominal film demonstrated air scattered in the small bowel and in the colon. A gallstone was present in the right upper quadrant (Fig. 1). Just below the gallstone gas was detected in the biliary tract. A subsequent gastrointestinal study demonstrated a normal stomach. However, the bulb was distorted, and there was a collection of barium extending from the duodenum (Fig. 2). At the time this was reported to be a duodenal ulcer. A colon study showed some diverticula in the sigmoid and descending portions of the colon. The remainder of the colon was normal. The evacuation film of the barium enema failed to demonstrate the gallstone which had been present on previous studies (Fig. 3). A collection of air was located where the gallstone had been. The plain film now had the appearance of small bowel obstruction.

DR. ROBERT GEURKINK: As in most patients with gallstone ileus, the correct pre-operative diagnosis was not made in this patient. His clinical course was atypical and the radiologic findings were misleading at the time of admission. In association with the Radiology Department, the patient was thought to have a penetrating duodenal ulceration, partial pyloric obstruction and small bowel obstruction, secondary to adhesions in the left lower quadrant. The history of diverticulitis seemed to support this contention. At the time of operation a large inflammatory mass was found in the right upper quadrant encompassing the gallbladder, the duodenum, and common duct. The gallbladder could not be identified and it was thought judicious to avoid this area. A posterior gastroenterostomy was performed. When attention was directed to the small intestine the first segment of small bowel de-



Fig. 1. Gallstone was detected in the right upper region of the abdomen by a plain film.

livered into the field contained a large concretion and it was obvious that this was the point of obstruction caused by a large gallstone impacted in a diverticulum of the jejunum. The bowel wall was thin and dusky and obviously required resection. A search of all the proximal bowel was made looking for other concretions and about eight inches proximal to the first stone another stone, approximately 2.5 cm. in diameter was found. The segment of small intestine containing the diverticulum was resected, the second stone was removed and an end-to-end small bowel anastomosis performed. His recovery was uneventful and he was discharged on the thirteenth postoperative day. He also had a large right scrotal hernia which some had thought was the source of his small bowel obstruction; however, this was reducible.

Gallstone ileus accounts for about one percent of mechanical small bowel obstructions. Maurer reviewed the German literature¹ and found 153 patients with gallstone ileus. The average age of the patients was 67. The correct preoperative diagnosis was made in only 17 percent. The author emphasized the search for other stones after

removal of the stone causing obstruction.

Because most of these stones become impacted in the terminal ileum and caused obstruction at that site, it has been suggested in the past that the stones can be "milked" into the cecum and allowed to pass spontaneously. This maneuver is unwise. In a panel discussion at the American College of Surgeons meeting in 1966, Dr. Harwell Wilson discussed this problem and stressed the danger of obstruction in the sigmoid colon from such gallstones. Many of these patients have diverticular disease and many have sigmoid narrowing. The treatment of choice is enterotomy and removal of the stones. In the German series of 153 patients a 41 percent mortality was reported. This high mortality was attributed to late diagnosis, advanced age, and associated disease. Chronic liver disease, diabetes and cardiovascular disease are frequent in the age group. The final consideration is cholecystoduodenal fistula.

Some will close spontaneously. The patient who was presented today was admitted eight weeks later for the repair of the inguinal hernia. Abdominal roentgenograms were obtained.

DR. CANNON: Review of the films, including a barium enema, failed to demonstrate evidence of air in the biliary tree on multiple projections.

DR. GUERKINK: Thus it appears likely that his fistula closed spontaneously, which will happen usually if the common duct is not

obstructed. His hernia was repaired and he went home eight days later.

DR. JOHN BEAL: One or two points merit emphasis. Gallstone ileus should be considered in a patient who develops small intestinal obstruction, who has had previous untreated biliary tract disease, and who has not had a previous laparotomy. There is a customary triad to be sought in these patients: air in the biliary tree, small bowel obstruction, and a calcific density seen usually in the right lower quadrant in the patient. There has been discussion recently whether or not the gallbladder should be removed at the time that the patient is operated upon for gallstones.

DR. CANNON: I would just like to say that air in the biliary tree just means that there is a fistula present, not necessarily due to a perforation or a gallstone in the duodenum. I have seen perforation of a duodenal ulcer into the common duct as well as a carcinoma of the hepatic flexure that perforated into the gallbladder. Therefore, the presence of the air is indicative of a fistula and additional studies are required to determine the cause.

Reference

1. Maurer, G.: Gallstone Ileus (Der Gallensteinileus). *Langenbecks Arch. Klin. Chir.* 308:176, 1964.



Fig. 2. Radiologic study of stomach and duodenum demonstrated extension of barium beyond wall of duodenum.

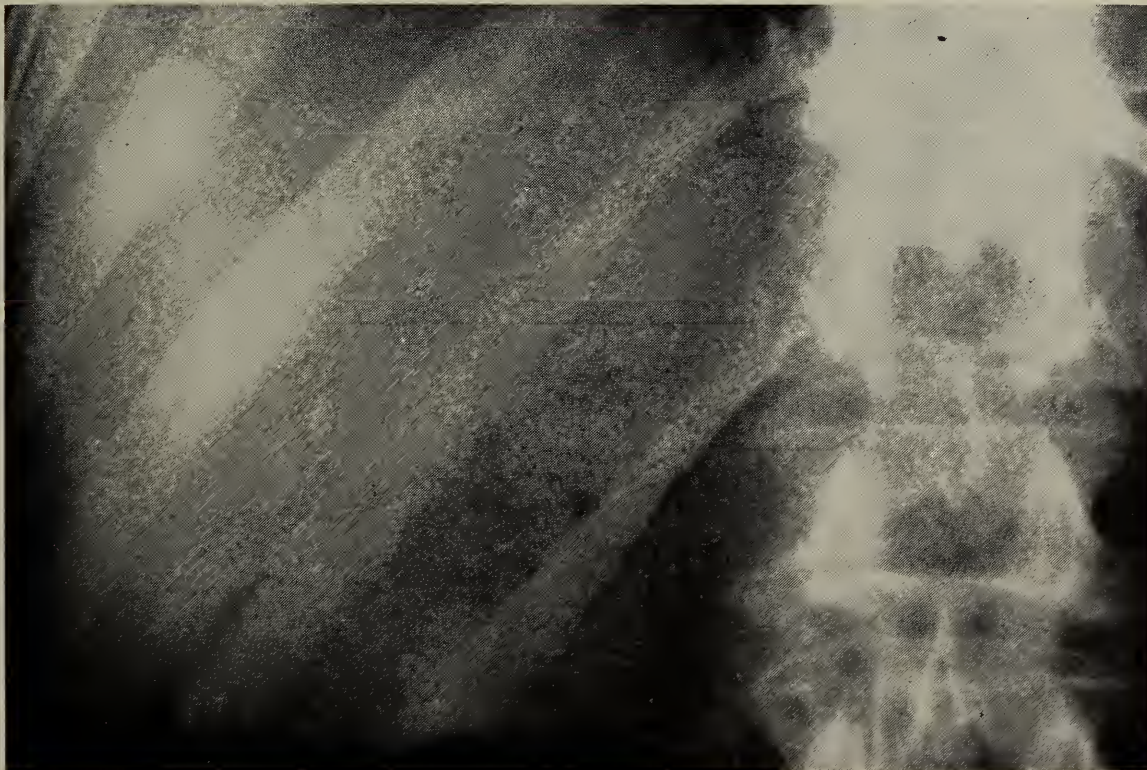


Fig. 3. Roentgenograms which were taken during barium enema show air in biliary tract with disappearance of gallstone (Fig. 1).

Modern Techniques in the Management of Pain

BY SEAN MULLAN, M.D./CHICAGO

Every doctor is well experienced in the management of pain. It is part of his daily practice. Whether it is the pain of cancer or of trauma or of some obscure neuralgia, he is all too familiar with it. He may well ask: "What has percutaneous cordotomy got to offer my patient?" For in the past it has been his experience that standard surgical cordotomy has been of limited value. In the past he has found that most patients who have had a series of operative attempts to control their disease were unwilling to accept yet another surgical procedure. When the neurosurgeon added that the patient must accept some risk of motor paralysis and of sphincter loss, when he could not promise that the operation would, in all cases, produce enough sensory loss to eliminate the pain entirely, and when it was known that sensation and pain could return in a few months or in a few years, it is understandable that this operation was advised and accepted in only the more desperate situations. But it must be remembered that many patients, who did accept these risks, achieved an outstanding and, in some cases, a long lasting relief.

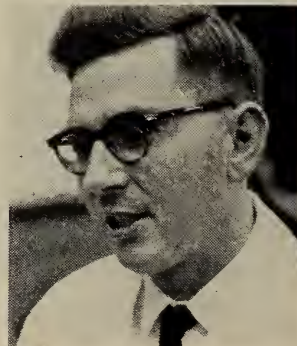
Our objectives have been to simplify the procedure from a major surgical operation (usually under general anesthetic) to a needle puncture (under local anesthetic), to eliminate all risk of motor or sphincter impairment, and to produce a long lasting

relief. In the course of more than 450 percutaneous cordotomies, we have advanced considerably towards these goals. (Some patients have had repeat cordotomies; a few have had a bilateral procedure). The methods so far developed are percutaneous strontium cordotomy, percutaneous electric D. C. (direct current) cordotomy, and percutaneous R. F. (radio-frequency) cordotomy.

The most useful of these is the R. F. procedure. All depend upon the anatomical fact that a needle may be easily inserted between the first and second cervical vertebra. Elsewhere overlapping laminae and articular processes of the vertebral column prevent easy needle access to the spinal cord. It is, however, possible but technically more difficult to enter the cord at a low cervical region through a cervical disc space. This low approach below the phrenic outflow eliminates the risk of respiratory impairment which is sometimes a problem with the higher procedure.

Needle insertion either at the standard C-1, C-2 interval or through a lower disc space is performed under local anesthesia without sedation using bilateral radiographic control. In a few patients we have experienced difficulty in obtaining a sensory loss by any method, despite many attempts and multiple punctures of the anterior quadrant of the cord. Whether the failure

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is a technical one or due to the fact that the pain fibers do not in all patients occupy the "average" position is undetermined. We are inclined to believe that there is some variation in the anatomical arrangement of these fibers and it must be remembered that the level of insertion is close to the medulla in which the spinothalamic tract assumes a more posterior position than in the cord.

Results in Cancer

By far the greater number of procedures have been done for the pain of terminal cancer.

Arm Pain. A higher level of sensory loss up to the tip of the shoulder sometimes up to the angle of the jaw can be produced by this method than has been our experience with standard surgical cordotomy. It is most suited for patients with infiltration of the brachial plexus due to carcinoma of the breast or of the lung. Some patients with extensive infiltration of the brachial plexus complain only of tingling or uselessness of the hand, rather than pain. The procedure will not relieve these discomforts.

Chest Pain. This is often associated with cancer of the lung and is seen with patients before treatment, in those who have had their lesion treated by radiotherapy and in those treated by surgery. It is mainly due to infiltration of the chest wall. Sometimes it is seen as a post-operative manifestation in patients in whom the gross tumor has been removed and is then presumably associated with injury to the intercostal nerve or nerves. Very satisfactory results are usually obtained. When tumor infiltrates the vertebral column a unilateral procedure is not adequate and at the moment we have no good answer for this pain. In the presence of actual or impending pulmonary failure it should be remembered that even a unilateral cordotomy may diminish respiratory function and precipitate pulmonary decompensation. A partial pneumonectomy does not contraindicate the procedure if the lung function is good. Neither is total pneumonectomy an absolute barrier but it does give concern.

Unilateral Pelvic and Leg Pain. Tumors of the pelvic organs, uterus, rectum, colon and bladder infiltrate the sciatic plexus and when the pain is unilateral percutaneous cordotomy gives excellent relief. Many patients who complain of pain on one side will admit to a very slight pain on



The patient lies supine. The needle is inserted below the mastoid process, between the laminae of C1 and C2, anterior to the dentate ligament.

the opposite side when questioned directly. These, and many who never complain of pain on the opposite side, even on direct questioning, may soon experience pain on the opposite side once the first one has been relieved. It would appear that a patient's attention is directed only to the major site of pain and that he can ignore a minor one. A minor one will, however, assume major proportions when the previously major one has been eliminated. This possibility should be explained to such patients before the initial procedure. We have not used the procedure extensively for carcinoma of the bladder because pain in this organ is often bilateral from the beginning.

Bilateral Pelvic and Leg Pain. This is a more difficult problem. The second side may be treated by means of the radio-frequency cordotomy at a lower level or in some instances by means of a slowly developing strontium lesion at the higher level, but as a rule we manage the second side conservatively for as long a period as possible. The bilateral high procedure carries some risk of respiratory difficulty and of more protracted urinary difficulty.

Long Bone Pain. Sarcomas and metastatic tumors in the long bones have responded well to the unilateral cordotomy.

Spinal Pain, Perineal Pain and Abdominal Pain. As these are transmitted by bilateral nerve pathways we have not used the procedure except in a few instances when there was a marked unilateral predominance.

Pain Associated with Irremovable Benign Tumors. Two patients with Von Recklinghausen's disease involving the brachial plexus, one with a solitary sciatic nerve neurinoma and one with a fourth lumbar

nerve root neurinoma have got good relief, so also has one patient with extensive angioma of the arm.

It is often difficult to decide on the best method of treatment for patients with terminal cancer. Some who complain bitterly of their pain are in fact acutely depressed because of the realization of having an incurable disease. When their pain is relieved by a cordotomy their total distress and symptoms may well shift to another somatic complaint, such as anorexia or loss of weight. Patients who complain of pain out of all proportions to the magnitude of objective signs may often be cared for better by sympathetic counselling and non-narcotic analgesics. When patients have only a few weeks to live it is probably better to manage by means of narcotic analgesics. The best results are obtained by using this cordotomy at an early stage of pain in order to allow the patient to continue life as normally as possible, rather than to allow him to become bed ridden because of pain or demoralized and disorganized by the use of heavy narcotics.

Non-Malignant Pain Post Inflammatory

Herpes Neuralgia. Cordotomy provides early and dramatic relief from this extremely severe pain. Late results when measured in terms of years are disappointing. The return of sensation to the denervated area is common many months after percutaneous cordotomy (as it has been after surgical cordotomy). With this return of sensation return of herpetic pain is probable. Repeat cordotomies are less satisfactory than the initial one. In addition some pain may return even though little pin prick is present as though alternate anatomical pathways were utilized in the pain transmitting process. Nevertheless, despite this long term limitation, even temporary relief is well appreciated by most patients with this distressing affliction.

Tabes Dorsalis. Our experience is too limited to speak on this subject with authority, but we have some evidence of improvement in patients with unilateral pain.

Post-Traumatic Neuralgia

Post-Surgical Scars. These are most commonly encountered with thoracotomy and have generally been a successful group.

Painful Amputation Stump and Phantom

Pain. Phantom pain occurring in the amputated limb and not related to pressure in the stump cannot be helped by this procedure. Pain in the phantom limb precipitated by squeezing upon the stump and pain in the stump precipitated by squeezing the stump can be relieved. Long term results are not available.

Brachial Plexus Avulsion. This behaves like an amputated stump. There is usually marked tenderness deep in the brachial plexus and the pain which can be precipitated by such pressure can be relieved.

Post-Traumatic Paraplegia. We have attempted to relieve this pain in a few conditions, but with disappointing results. This follows the general rule that when there is peripheral pain precipitated by irritation, compression or other external stimulus, the results are good, but when there is intrinsic damage to the pain conducting mechanism itself, the results are much more unpredictable and unsatisfactory.

Miscellaneous Pains

Pain Associated with Disc Disease. This is an extremely large and difficult problem. In a few with strictly unilateral pain we have had some success. We have not tackled the vast majority of patients with such problems because of the bilateral nature of their complaints and because of psychiatric and legal complications.

Osteoarthritis of the Hip. In three patients osteoarthritis of the hip was unsuited to definitive orthopedic treatment because of age and debility and in these satisfactory relief was obtained by cordotomy. In another patient who also expected improved mobility, pain was relieved, but complaints were not greatly lessened.

Diabetic Neuropathy. In a few patients with diabetic neuropathy with pain in one leg only we have been able to effect relief. This unilateral pain in diabetics, which often mimics sciatica of intervertebral discs origin, is well known to be refractory to intervertebral disc surgery.

Pain Without Recognized Cause. We have attempted to relieve a few disabling pains in which we did not understand the mechanism or the cause. Although we have had a few rather dramatic successes, we have had several failures and we wonder whether the power of suggestion played any part in the successes.

Complications

Mortality. In a series of more than 450 cordotomies we have had nine deaths. Four were associated with bilateral lesions and five with unilateral lesions in patients with lung failure. We no longer advise the high cordotomy when lung failure exists. There have been no deaths in patients with normal lung function.

Paresthesias. These have occurred especially during the late period of returning sensation. Their unpredictable occurrence is the main reason for caution in advising the procedure for the less severe grades of benign pain. Although not absolutely distressing in any instance they certainly have been a significant nuisance.

Weakness and Bladder Incontinence. These are temporary problems which disappear within a few days or a few weeks.

Discussion

The last six years have been a period of progressive development of technics. We feel that a very satisfactory cordotomy, virtually without complications, can now be offered to most patients with unilateral pain due to cancer. It can be offered even to the octogenarian and to the debilitated but not to the patient in pulmonary failure. In a few patients, however, we have failed to produce a satisfactory sensory loss despite multiple punctures, stimulations and lesions in the anterior cord.

We believe that percutaneous cordotomy is superior to standard surgical cordotomy in its simplicity, in its accuracy and in its safety. It is simple because it eliminates an anesthetic, an incision and a period of post-operative care. It is more accurate because we have an alert, cooperative patient, a well visualized cord (radiographically) and the advantages of motor tract location by stimulation. It is safer because it eliminates the danger of an anesthetic and of motor paralysis.

At the present time, bilateral pain is not suited to percutaneous cordotomy except in a few rare instances. This is because of the dangers of bladder impairment and of respiratory impairment. (Motor impairment can be prevented by motor testing during the procedure). Whether the procedure can be adapted to eliminate the risks inherent in bilateral lesions remains for the future. This means that at the present time, spinal

pain, abdominal pain, and perineal pain are not amenable to this method.

Pains due to benign disease must be approached with caution because of the difficulty of evaluating their intensity, because of the problem of the uncertain duration of cordotomy relief and because of the occasional occurrence of paresthesias. Nevertheless, very satisfactory relief can be obtained in this group in the well selected patient. We have been particularly pleased with the results for painful amputation stump, painful brachial plexus avulsion, painful thoracotomy scars and for some cases of post-herpetic neuralgia.

One must also mention the limitations imposed by narcotic addiction. It is very difficult to estimate the intensity of pain in the presence of addiction and difficult to predict the future course. Some have complained of pain elsewhere as severely as they complained of their original pain. Some have complained of their original pain, despite complete pin prick loss in this area. However, a number have got relief and have been able to withdraw completely. We have also had a few pleasant experiences in relieving pain by successful narcotic withdrawal only, without the use of cordotomy. Despite such rare experiences, it would seem reasonable to state that if a patient has a reasonable life span, it would seem desirable to have a percutaneous cordotomy done before an addiction pattern becomes established, even with the simpler narcotic drugs.

We have avoided those pains in which legal complications have played a major part.

Summary

1. Percutaneous cordotomy is a simplified form of surgical cordotomy. It interrupts or destroys conduction of pain in the pain pathways of the spinal cord. We believe it is simpler, more accurate and safer than surgical cordotomy.

2. It is performed under local anesthesia by inserting a needle into the neck, below and behind the mastoid process. The needle is guided into the spinal cord by biplane X-ray control.

3. The unilateral procedure is virtually without complications. It is of most value for the pains of cancer. Its place in the management of post-herpetic and post-

(Continued on page 659)

Improved Method of Bronchography In Uncooperative Patients Respiratory Diseases In Institutions for the Mentally Retarded

BY ALEXANDER A. KALUZNY, M.D., RAFAEL SILVA, M.D., AND SAUL PARKS, M.D.

Among the most common physical ailments in the institutions for the mentally retarded are the respiratory diseases. The susceptibility of retarded patients to aspirations and infectious agents is well known. In institutions in England 16 per cent (of the residents) died of tuberculosis, 22 per cent of infectious pulmonary diseases and 9 per cent of other infections.¹

The morbidity and mortality from respiratory diseases among the residents of institutions for the mentally retarded is greater than that among the non-institutionalized mental patients, and definitely higher than among the general normal population. This is due both to the environmental factors and to constitutionally lower resistance. The latter is refuted by some authors. The lack of understanding of the simplest rules of hygiene and sanitation on the part of the patient is also a factor in the high incidence of disease. Mongoloids, which are common in these institutions, are known to have respiratory mucosa which is extremely susceptible and vulnerable to infections. Tuberculosis is extremely frequent in these patients. Prior to the availability of specific mycobacterial therapy, 75 per cent of Mongoloids above the age of 10 years died of this disease.²

The Dixon State School is the second largest institution in the State of Illinois for the mentally retarded with a population of approximately 5,000 residents. As would be expected, respiratory diseases are the most common entity encountered at the medical services. The incidence of respiratory diseases in the 11 months ending Dec. 1, 1966, were 255 cases out of 1,111 hospital admissions (23.4 per cent). Of 125 deaths during this period, 40 per cent were due to

various types of pneumonias. Of 75 cases which came to autopsy, 50 per cent demonstrated pneumonia. The total number of primary broncho-pneumonias at Dixon State School from 1965 to 1966 was 45, and the total from 1966 to 1967 was 50. The total for primary and secondary broncho-pneumonias for 1965 to 1966 was 65, and the total from 1966 to 1967 was 60—as is shown in the table in Fig. 1A.

At the Dixon State School patients with respiratory infections are handled by the general medical staff except for suspected cases of tuberculosis which are cared for by the chest service consisting of a thoracic surgeon, chest physician and radiologist. In special cases the chest service is called in consultation by the staff physicians for further diagnosis and care. Every effort is made to establish a definite diagnosis wherever possible. The behavior and condition of the patient have been determining factors in the choice of diagnostic procedures. The use of conventional chest x-rays, tomography, fluoroscopy, bronchoscopy and bronchography have been heavily relied upon in arriving at an anatomic diagnosis. Bronchography has been found to be very useful in studying the cases with special problems. In order to extend the use of bronchography in a greater number of patients who are mentally handicapped, we have devised a special curved bronchogram needle with the cooperation of the Becton Dickinson Co. This needle has been in use since 1961 with a high degree of success in all types of patients, including those formerly considered unmanageable. This method of bronchography will be discussed in detail.

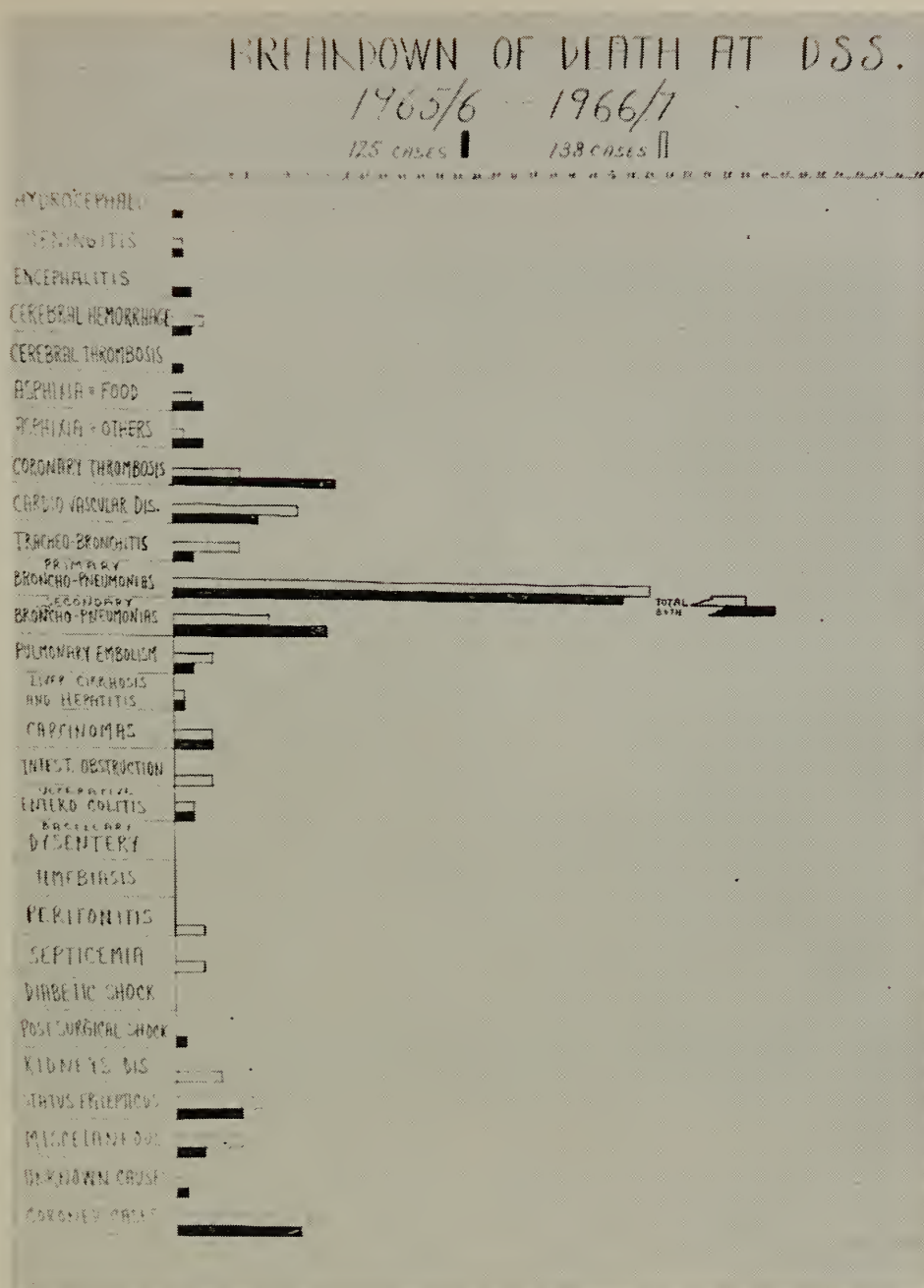


Fig. 1A Table showing incidence of primary and secondary pulmonary infection in Dixon S.S.

Procedure:

The patient is placed in the supine position on the x-ray table with shoulders elevated by a folded sheet to permit hyper-extension of the neck (Fig. 3)

Better cooperation is obtained if the patient is wide awake, but if necessary analeptics, hypnotics and even general anesthesia can be used. After sterilization of the skin of the neck, the skin below the level of the cricoid cartilage is anesthetized in the midline as is the subcutaneous tissue in front and on both sides of the trachea at

this level with 0.1 per cent procaine solution. (Fig. 4, 5 & 6).

In order to minimize the cough reflex when the bronchogram needle is inserted, 1 cc of 0.5 per cent pontocaine is injected into the trachea directly below the cricoid cartilage with the 22 g straight needle at this time. (Fig. 7 & 8).

A small horizontal incision is then made (Fig. 9) and the curved bronchogram needle is pushed through the incision as follows: The operator's left hand pinches the skin at the point of incision while the point of the needle is introduced through the in-

METHOD OF BRONCHOGRAPHY USING THE CURVED B-D 01-0144 SILVA BRONCHOGRAM NEEDLE

Equipment and supplies needed (Fig. 1)

2 cc syringe for pontocaine 25g intradermal needle
5 cc syringe for procaine 22g hypodermic needle
Scalpel with bayonet blade (No. 11)
Contrast media—Dionosil oily

50 cc syringe for contrast media
0.5% pontocaine solution
1.0% procaine solution
Sterile gloves
Umbilical tape
Silva bronchogram needle (Fig. 2)



Fig. 1 Tray shown, equipment and supplies needed.



Fig. 2 Silva bronchogram needles (B-D 01-0144, Benton-Dickman Co.).

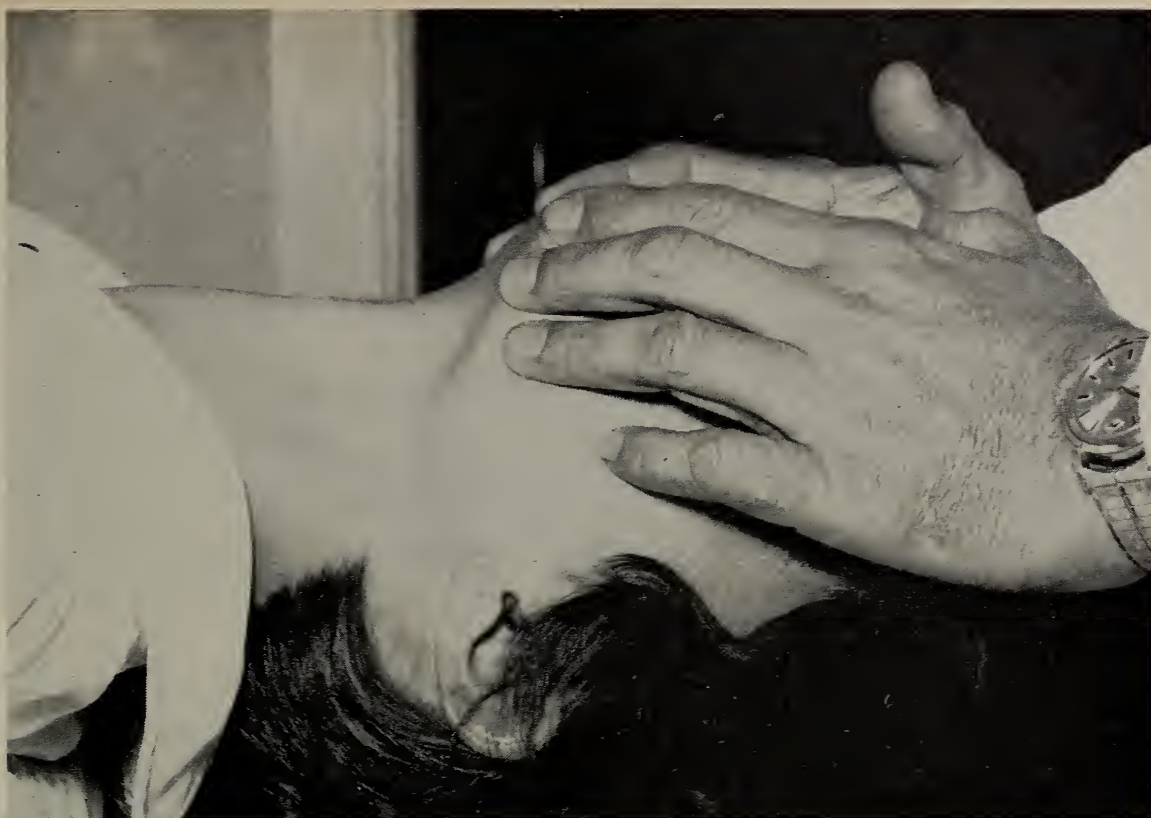


Fig. 3 Neck, in hyperextension in preparation of beginning procedure.



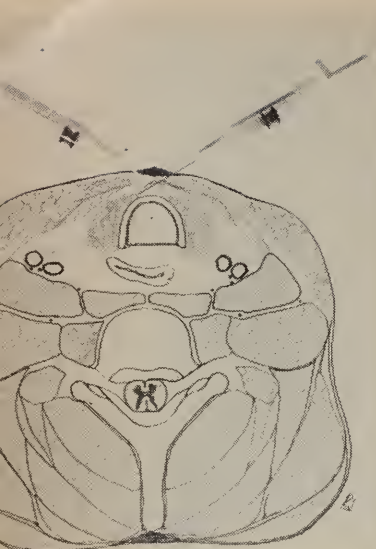
Fig. 4 Cross section of neck showing site of dermal infiltration of skin.

cision with the right hand. (Fig. 10). The needle is then forwarded through the anterior fascia of the neck down to the anterior surface of the trachea. The left hand then releases the skin and immobilizes the trachea between the thumb and the index finger. With the right hand guiding, the tip of the needle is placed in the space



Fig. 5 Neck and hyperextension showing intra-dermal anesthesia.

between the cricoid cartilage and the first tracheal ring. Pressure is then applied over the horizontal part of the curved needle to push it into the trachea. The needle should be inserted with its long axis in line with the long axis of the trachea and pushed all the way to the guard. If the needle is correctly placed in the tracheal lumen, the sound of air through the needle will be readily audible after removing the stylet.



6 Cross section of neck showing infiltration of the subcutaneous tissue.



Fig. 7 Infiltration of Skin. Side view of Fig. 4.



Fig. 8 Injecting pontocaine directly into the tracheal lumen.



Fig. 9 Making horizontal incision prior to injecting the curved bronchogram needle.



Fig. 10 Inserting bronchogram needle.

The guard of the needle is curved outward to permit greater stability and prevent accidental removal of the needle after it is secured in place with umbilical tape tied around the neck (Fig. 11, 12, 13, & 14). If there is any doubt about the needle being in the tracheal lumen, the procedure of insertion should be repeated. Fig. 15 shows aspirating air through the syringe indicating that the needle is in good position.

With the needle in its proper place, the trachea and bronchial tree should then be anesthetized by injecting 0.5 per cent pontocaine into the lumen until the coughing reflex is completely eliminated. We have found that 3 ml. dropped into the trachea and the bronchi should be sufficient for this purpose. (Fig. 16) If necessary more than 3 ml. can be used.

The contrast media is now injected into the tracheo-bronchial tree, the position of the patient being varied to obtain the optimal filling. (Fig. 17) Filling may also be made under direct fluoroscopic³ control using a venotube (Abbott) adaptor between the syringe and needle to reduce exposure to the operator. Appropriate films are then taken either in the upright or recumbant positions. We usually fill the pathological side first and take the appropriate films. After taking these films and demonstrating the abnormality, complete 5 lobe filling is then done.

After the procedure is completed, the needle is removed and the puncture wound is covered with a band aid. The patient should be encouraged to expectorate as much of the contrast media as possible. The

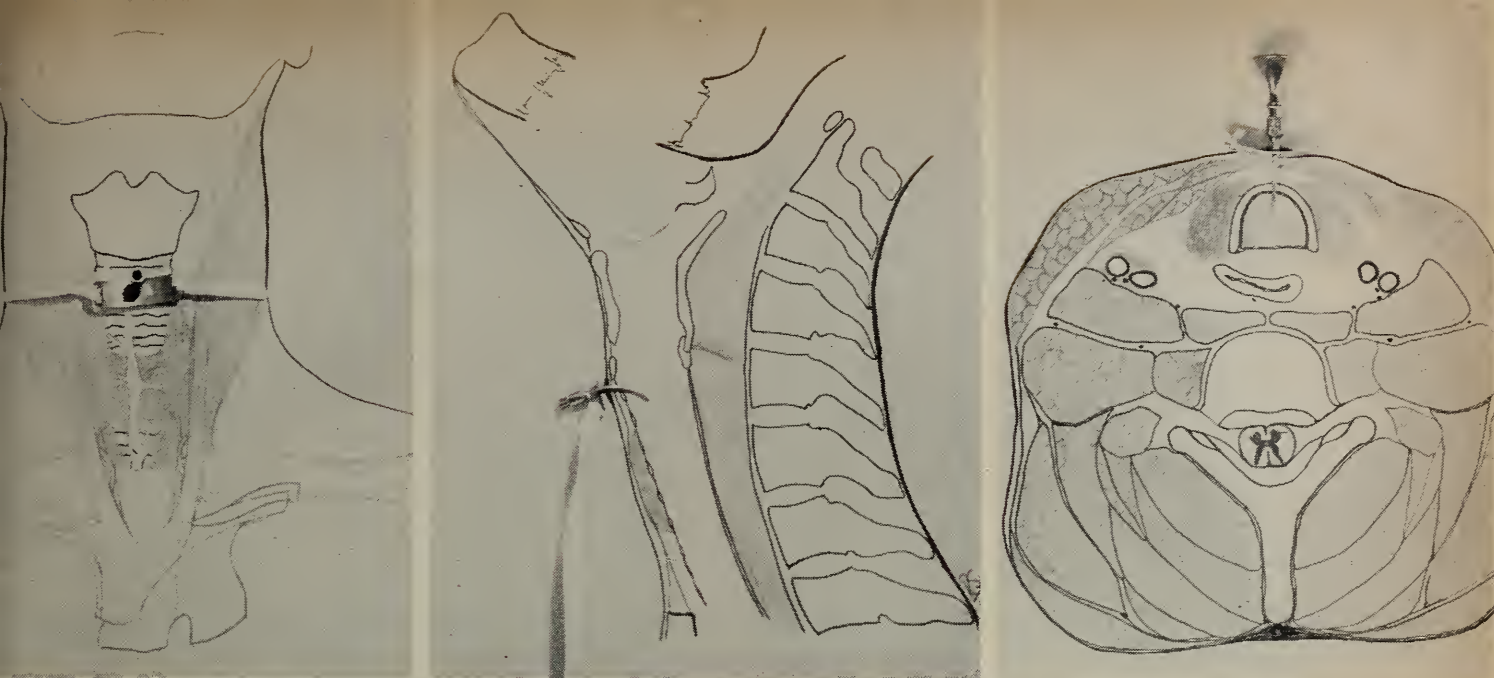


Fig. 11, 12, 13 Schematic illustration of bronchogram needle in sites P.A., Lateral views and cross section of neck.



Fig. 14 Needle in place with tape tied around the neck.

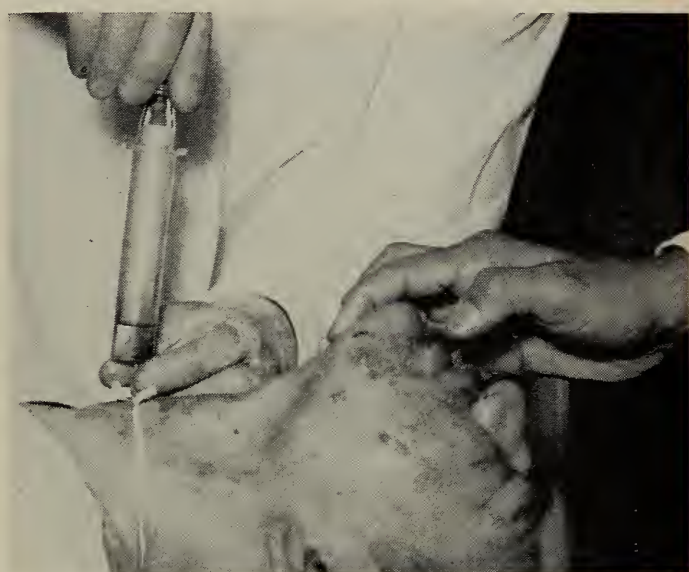


Fig. 15 Drawing air to be sure we are in trachea.



Fig. 16 Injecting topical anesthesia into the trachea.

delayed occurrence of subcutaneous emphysema of the neck may be prevented by using an ice pack on the neck.

A series of bronchograms showing the various types of filling obtained with our technique is shown in Figure 18 thru 23. The patient with left lower lobe bronchiectasis underwent left lower lobectomy and he is in satisfactory condition. (Fig. 24).

Since 1960 the transtracheal method of bronchography using the curved Silva

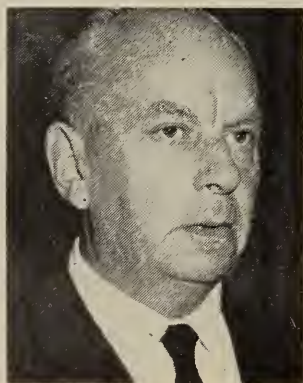
needle has been in use in this institution and other hospitals in the area. It has been used in 66 bronchograms, on 41 mentally retarded patients and on 25 normal patients in various hospitals. Of the entire group, 22 were female and 44 males, which reflects the usual incidence of chronic lung disease in the United States. Of the bronchograms done 23 were found to be normal and 43 showed pathology. Pathology found on bronchography were as follows:

Bronchiectasis	— 20 cases
Carcinoma	— 10 cases
Lung abscess	— 3 cases
Others (chronic bronchitis with complications)	— 10 cases

The ages of the patients varied between seven and 74 years of age. (Fig. 23) From Dr. F. H. Kemp, Radcliffe Infirmary, Oxford, England, member of the Visiting Faculty at the Symposium on Chest Radiology offered by the University of Kentucky Medical Center, May 1967, we learned that transtracheal bronchography is a popular method in his area. And finally among other specialists, Dr. Jerome R. Head, Chicago, for many years has followed a similar technique but using a straight needle instead. Dr. George C. Evans, Philadelphia is a great promoter of this system.

Summary

A study of 66 bronchograms done using the transtracheal method with the improved Silva curved needle, BD 01-0144, is reported showing the efficiency and ease of the technique. No ill effects were encountered. The series included patients from seven to 74 years of age, involving normal, as well as several mentally and physically handicapped subjects who ordinarily would not have had the benefit of this valuable diagnostic procedure. The technique using the Silva curved bronchogram needle is described in detail.



Dr. Alexander A. Kaluzny (left)
Acting Chief Medical Officer
Illinois Department of Mental Health

Dr. Rafael E. Silva (far right)
Chief of Thoracic Services
Dixon State School
Illinois Department of Mental Health

Dr. Saul L. Parks (right)
Director Radiological Services
Dixon State School
Illinois Department of Mental Health



Fig. 17 Positioning the patient for upper lobe filling.

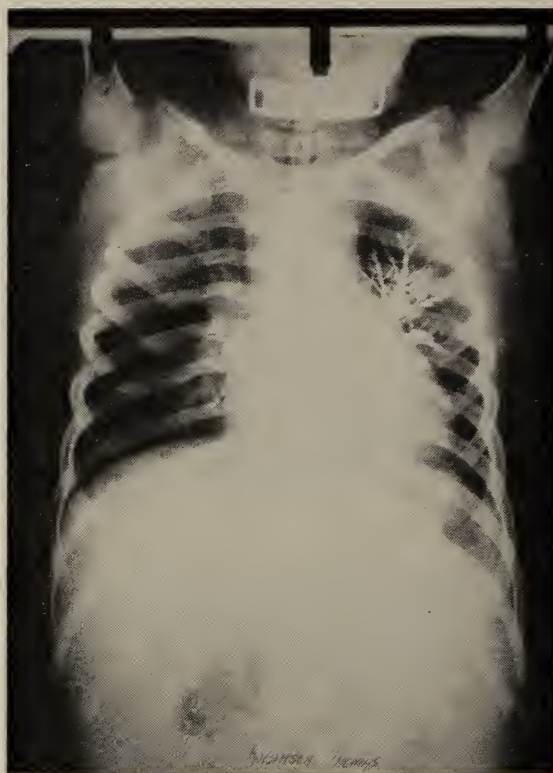


Fig. 18 Bronchiectasis case.



Fig. 19

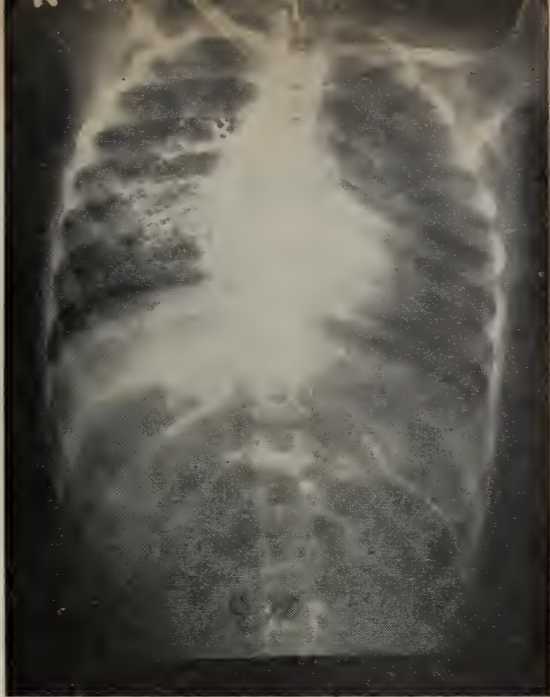


Fig. 20

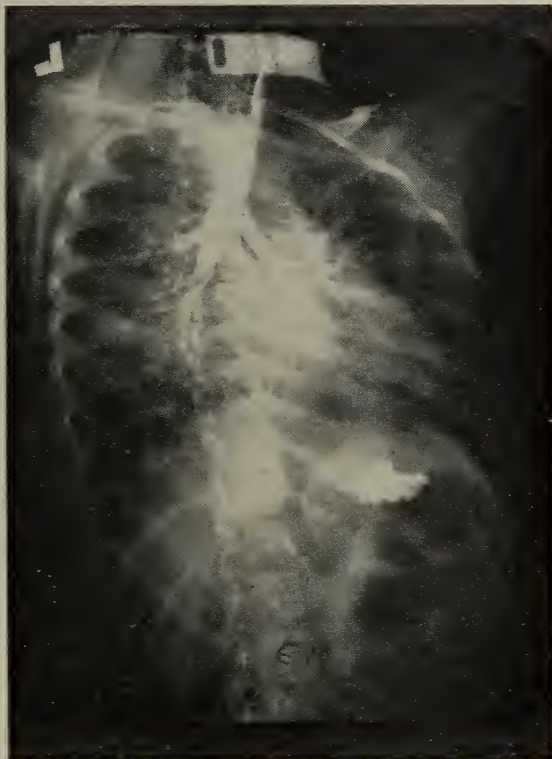


Fig. 21

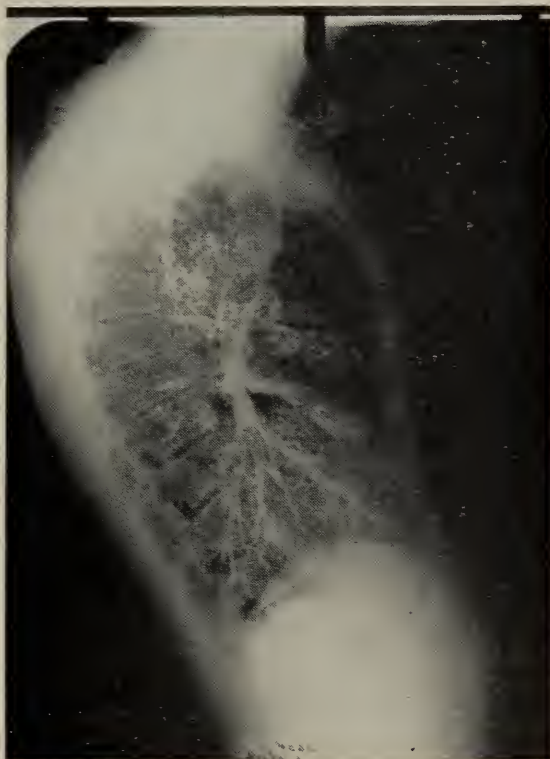
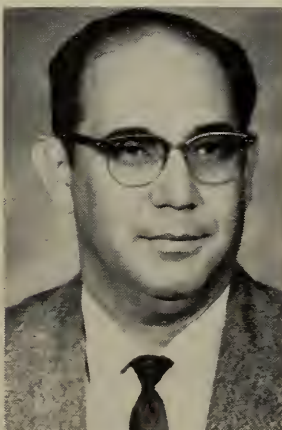


Fig. 22



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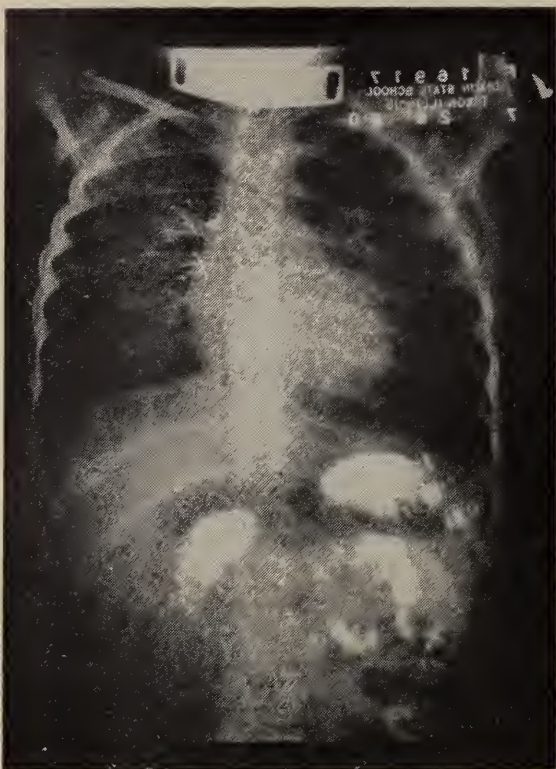


Fig. 23 This is a patient 7 years old.

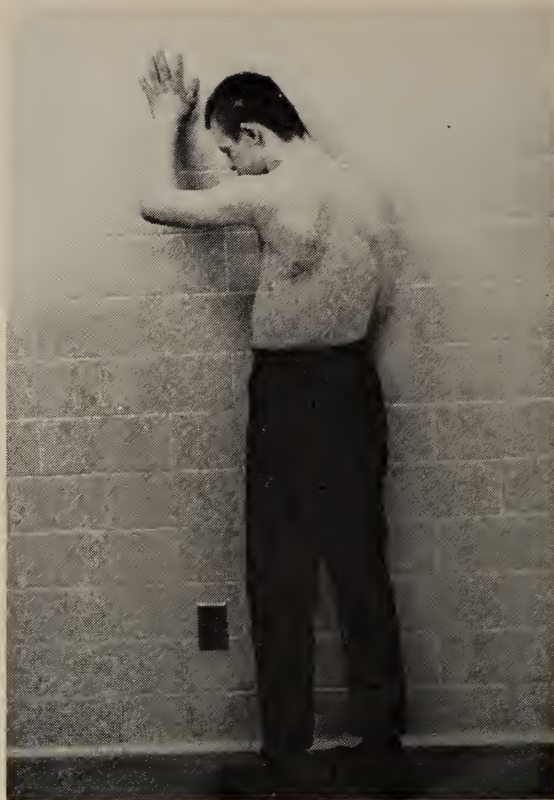


Fig. 24

S. S. Hope Team to Work in Ceylon for 10 Months

The hospital ship S.S. HOPE has sailed for Ceylon to begin the project's most comprehensive medical teaching and treatment mission to date.

The ship departed Feb. 29 from Philadelphia, arriving in Colombo, Ceylon, on April 15.

In Ceylon, the HOPE team of 150 physicians, dentists, nurses and technicians will work for 10 months with Ceylonese medical counterparts. The arrival of the ship was preceded in June, 1967, by a visit of a HOPE survey team which met with Ceylonese officials to determine needs and to outline an educational-exchange program. In January, 1968, an advance team of HOPE permanent staff members flew to Colombo to prepare for the ship's arrival.

In Ceylon the S.S. HOPE is serving as an affiliated hospital to the medical schools and to the hospitals in Colombo and the inland city of Kandy. Patients are referred to the ship by a HOPE committee made up of Ceylonese medical professionals. HOPE medical teams work with their counterparts not only on the ship, but in clinics, classrooms and hospitals ashore.

HOPE went to Ceylon at the invitation of the Ceylonese government and the Ceylonese medical profession. The mission marks the ship's first return to Asia since the maiden voyage to Indonesia and South Vietnam in 1960. Since then, HOPE has visited Peru, Ecuador, Guinea, Nicaragua and Colombia. HOPE shore-based programs continue today in four of those nations.

Founded in 1958 by Dr. William B. Walsh, Project HOPE is the principal activity of The People-to-People Health Foundation, Inc., an independent, non-profit corporation supported by the American people. Since the first voyage, more than 1,100 American medical personnel representing all 50 states have served with the Project. The HOPE staff has trained 4,017 medical personnel, treated over 120,000 persons, conducted some 10,778 major operations, and benefitted more than two million people through immunization, examinations and other services.

The Veterans Administration pays more than \$800 million annually to G. I. insurance policyholders and their beneficiaries.

Clinical Trial of a Unique Hydrocortisone Containing Topical Aerosol in a Variety of Dermatologic Disorders

BY RALPH WISE, M.D./SPRINGFIELD

The role of the topical steroids in a variety of dermatologic disorders is well established. As a consequence, the choice of a preparation is often a matter of cosmetic appeal and patient acceptance. The present study was undertaken to demonstrate the efficacy and evaluate the patient acceptance of a hydrocortisone-containing topical aerosol foam* in patients with a variety of dermatoses.

Ninety-eight patients were selected from private practice to evaluate the clinical response to the topical aerosol. Seventy patients had contact dermatitis. In most cases this was due to poison ivy, wild parsnips or other plants, but in a few instances contact with materials such as rose dust had induced the dermatitis. There were 14 patients with pruritus ani, six with neurodermatitis, and eight others with miscellaneous dermatologic disorders such as tinea cruris, intertrigo, and drug allergy. Table 1. presents a description of these patients.

*Hazel-Balm H-C supplied by Arnar-Stone Laboratories, Inc., Mt. Prospect, Ill. 60056.

Table 1.

Description of Patients			
Diagnosis	Men	Women	Average Age (Range)
Contact Dermatitis			
Used alone	18	11	21 (2½ to 68)
Used with other drugs	23	18	28 (7 to 70)
Pruritus Ani			
Used alone	10	0	43 (17 to 70)
Used with other drugs	4	0	46 (39 to 56)
Neurodermatitis			
Used alone	1	2	81 (76 to 88)
Used with other drugs	2	1	61 (40 to 77)
Miscellaneous			
Used alone	3	0	44 (2 to 72)
Used with other drugs	3	2	37 (17 to 58)
TOTALS	64	34	— ————
AVERAGE	—	—	32 (2 to 88)

The hydrocortisone-containing aerosol foam was used for symptomatic control in all cases. It contains:



Ralph W. E. Wise, M.D., is on the attending staff at St. John's Hospital and Memorial Hospital, Springfield. He received his M.D. from the University of Iowa and served an internship at the University of Wisconsin General Hospital. Residencies were taken at the Mayo Foundation, Rochester, Minn.

Hydrocortisone	20%
Hamamelis water (containing 15% alcohol)	79.16%
Water-soluble lanolin derivative	10.00%
Benzethonium Chloride	0.10%

In 55 cases the aerosol was applied every two hours. In 25 patients application was four times daily. The average duration of therapy was six days. In addition to the topical preparation described above, other medications (antihistamines most commonly) were used in 41 of 70 patients with contact dermatitis, 4 of 14 with pruritus ani, 3 of 6 with neurodermatitis, and 5 of 8 patients with miscellaneous dermatologic disorders. Other concurrently administered medications included steroids and tranquilizers.

For purposes of statistical evaluation the clinical response in each case was assigned a numerical score as follows:

Excellent	5
Very good	4
Good	3
Satisfactory	2
Poor	1
No response	0

Results

The average duration of therapy and the symptomatic response in each of the diagnostic categories is shown in Table 2.

Table 2.

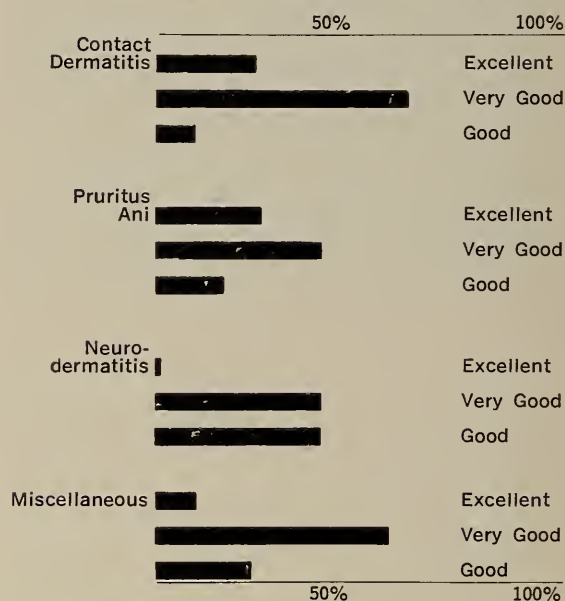
The Response to Therapy

Diagnosis	Average Duration of Therapy	Excellent	Very Good	Good	Score
Contact Dermatitis					
Used alone	4	11	17	1	4.16
Used with other drugs	6	6	30	5	4.32
Pruritus Ani					
Used alone	7	3	4	3	4.07
Used with other drugs	8	1	3	0	3.90
Neurodermatitis					
Used alone	10	0	2	1	3.50
Used with other drugs	12	0	1	2	
Miscellaneous					
Used alone	5	0	3	0	3.88
Used with other drugs	6	1	2	2	
<hr/>					
TOTALS	—	22	62	14	—
AVERAGE	6 days	—	—	—	4.08

The response was considered to be excellent, very good, or good in all 98 patients. Concurrent therapy with other preparations produced a slightly better average score in patients with contact dermatitis (4.32 as compared with 4.06), but in patients with pruritus ani the average score was slightly better when the hydrocortisone-containing aerosol was used alone (4.07 as compared with 3.90).

For comparative purposes the data in Table 2. were converted to percentages for presentation in Figure 1.

Figure 1.
Percentage of Patients Responding



The remarkable efficacy and excellent patient acceptance characteristic of therapy with this aerosol preparation may be illustrated by three brief case reports.

Patient J.O. was a 40-year-old man who had poison ivy nearly every summer. The aerosol was applied four times daily with a very good response within four days. The patient thought that it was the best medication he had ever used for his pioson ivy. No other drugs were used concurrently.

Patient E.M. was a 40-year-old man with pruritus ani. There had been a mild galling reaction with itching of the gluteal cleft for a period of two years. The aerosol was applied three times daily with excellent control of the condition within seven days. With occasional use of this aerosol there has been no subsequent recurrence.

Patient H.F. was an 88-year-old woman with severe neurodermatitis. Itching was

severe and recurrent. Although other topical preparations had proved to be irritating, good control of the itching was achieved with the aerosol applied every two hours. Patient acceptance was excellent, and no other preparations were used concurrently.

The only side effect noted was a slight stinging sensation with the first application of the aerosol in a patient with pruritus ani. Therapy could be continued in this case, and there were no other side effects.

Discussion

We found this unique aerosol foam to be a highly efficient means of delivering a thin film of medicated foam over relatively large skin areas without annoying the patient by undue spreading. Since the topically applied steroids are not absorbed to any clinically significant extent, there were no systemic side effects even with widespread application. Ease of application, absence of a greasy base, and a high degree of therapeutic efficacy contributed to excellent patient acceptance. The aerosol had a soothing effect (except for the one patient who reported an initial stinging sensation), and there was

no undue dryness of the skin with prolonged use.

Summary

The effects of a hydrocortisone-containing topical aerosol were studied in 98 patients selected from private practice. Seventy had contact dermatitis, there were 14 with pruritus ani, six with neurodermatitis, and eight others with miscellaneous conditions such as tinea cruris and intertrigo. In most patients the topical aerosol was used every two hours. Therapy was continued for an average of six days. Other medications, primarily antihistamines, were used concurrently in 53 patients.

The response was excellent in 22 patients, very good in 62 and good in 14. Based on a numerical scale of 5 (excellent) to 0 (no response), the average score was 4.08 ± 0.60 . Patient acceptance of the aerosol formulation was uniformly good, and this important aspect of therapy is demonstrated by three brief case reports. One patient with pruritus ani reported slight stinging with the first application. There were no other side effects.

Computerized Patient Under Study at University of Illinois

A computer programmed to react as a patient will be studied as a teaching tool in a \$215,000 Public Health Service supported project at the University of Illinois College of Medicine.

Principal staff members for the study at the University's Center for the Study of Medical Education are: George E. Miller, M.D., Director of Research in Medical Education, and Mitchell Schorow, B.A., M.A., Chief, Instructional Systems Section, and John Marxer, B.A., M.A., Associate, Instructional Systems Section.

According to Dr. Miller, "a five terminal computer facility in the Center for the Study of Medical Education at the University will be realized through this grant, and will be dedicated to the exploration of clinical problem simulation."

"The project has two major goals," he continued. "The first is in research: to study problem-solving techniques from the first year medical students to the practitioner in all stages of his career; to establish a library of clinical problems; and to develop an in-

dividual diagnostic performance output system. The second is in instruction: to provide clinical problem encounters for medical students."

The two year project totals \$215,000 and is entitled: "Computer Simulation of Clinical Encounters." The grant is to be administered by the Division of Physician Manpower of the Bureau of Health Manpower, an agency of the Public Health Service.

Schorow, project director, has noted that the problem encounter is a highly sophisticated use of the computer system that requires greater programming skills and preparations prior to the student's participation. The student finds the computer easy to use. He "examines" simulated patients, makes a diagnosis and prescribes therapy. All this is done at a typewriter-like keyboard that a student can use effectively after 10 minutes of instruction.

To strengthen retention and offer challenging clinical problems to students, the center's staff developed and programmed

(Continued on page 656)



THE VIEW BOX

By LEON LOVE, M.D.
Clinical Professor of Radiology,
Chicago Medical School,
Director, Dept. of Diagnostic Radiology
Cook County Hospital, Chicago



Fig. 1.

This patient was a four-week-old infant who was admitted to the hospital because of septicemia, diarrhea and fever since the second week of life.

Physical examination revealed an acutely ill infant with a T 102° with some abdominal distension but no obvious abdominal tenderness.

WHAT'S YOUR DIAGNOSIS?

- 1) Meconium ileus.
- 2) Pneumatosis intestinalis.
- 3) Meconium Plug Syndrome.
- 4) Hirschsprung Disease.

(Answer on page 626)

Medical Progress in the Prevention of Childhood Lead Intoxication

By JOSEPH GREENGARD, M.D., LOWELL ZOLLAR, M.D., MPH.,
MANOUCHER SHARIFI, M.D./CHICAGO

In general, prophylaxis is the only truly effective therapy of lead poisoning in young children. The primary step is the removal of the child from the source of the poison. Since lead poisoning almost exclusively occurs in deteriorated slum dwellings, the clearance and replacement by new housing free of lead containing paint is needed.

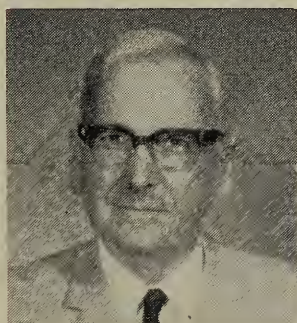
A second, less effective and extremely laborious method is the search in known neighborhoods of high incidence for small children who already have acquired an increased body burden of lead.^{1,2} The geographic areas in individual cities are known, as well as the age group, the one-to-five year old toddler. One can then proceed with house to house surveys in the painful effort to detect the affected children. This report is concerned with such a survey conducted in 1966-1967.

Material And Method

Cook County Hospital is located on the near west side of Chicago and draws its clientele largely from the immediate vicinity and from the Lawndale area, a teeming, densely populated old neighborhood extending roughly west and southwest of the hospital, almost to the city limits.

Approximately 99 percent of the population is Negro. They live in old houses, badly deteriorated and divided into multiple units, with consequent severe overcrowding. A smaller portion, also largely Negro, derive from the south side of Chicago where some degree of rehabilitation has been achieved.

The method employed in case finding consisted of a door-to-door canvas by public health and volunteer workers. Where children in the one-to-five year age group were present, urine specimens were requested and when obtained, analyzed for coproporphyrin III in the laboratories of the Chicago Board of Health. When a definitely positive reaction was reported, the parent was instructed to bring the child to the outpatient area of Cook County Children's Hospital. A careful history was taken, inquiring specifically for evidences of pica^{3,4} and the presence of loose plaster or peeling paint in the home. A complete physical examination was done paying particular attention to evidences of anemia or central nervous system involvement. A specimen of whole blood was drawn in a lead-free vacutainer tube for quantitative lead analysis; x-rays of the abdomen and knee and a complete blood count were done.



Joseph Greengard, M.D., (left) was director of the Division of Pediatrics, and Attending Pediatrician, Cook County Hospital. He received his medical degree from the University of Illinois School of Medicine and served his internship and residency in pediatrics at Cook County Hospital. Since the completion of this survey Dr. Greengard has moved to California and is now Clinical Professor of Pediatrics at Loma Linda Univ.

Lowell M. Zoller, M.D., M.P.H., Chicago (right) is associate attending pediatrician in the Division of Pediatrics, Cook County Hospital and is engaged in private practice. He was chief resident in pediatrics at the time of the study. Dr. Zoller received his medical degree

from Howard University. He served his internship and residency at Cook County Hospital.

Manoucher Sharifi, M.D., Waukegan, assisted in the survey presented in this article. He was a resident in pediatrics and Director of the Out-Patient Clinic at Cook County Hospital. Dr. Sharifi received his medical degree from the University of Tabriz, Iran and interned at Augustana Hospital, Chicago.



Results

We consider the blood lead level the best guide to the diagnosis of clinical intoxication. A total of 812 children were referred to the hospital by the survey workers. Five hundred and forty one (66.6%) reported as directed. One third of the original survey group could not be examined. Fourteen children (2.58%) were admitted to the wards immediately with positive x-ray or clinical findings considered sufficiently suggestive of lead intoxication to warrant in-patient care. Forty seven children were discharged as free of evidence of high tissue storage.

Table 1.
Lead mcg. per 100 grams whole blood

Total cases	59 mcg or <	60-79	80-149	> 150
490	231 47.14%	118	114	27
52.86%				

Distribution of cases on the basis of the initial blood lead level. Sixty micrograms per 100 grams whole blood is considered the upper limit of normal.

The remaining 490 children, all essentially asymptomatic, were managed in the clinic. Their disposition was based upon the initial blood lead level obtained, 60 micrograms per hundred grams whole blood being accepted as the upper limit of normal. Two hundred and thirty one (47.14%) of these 490 children had levels below this figure, while 259 (52.86%) were above. Thus, slightly over one-half could be classified as having potentially dangerous blood lead levels.

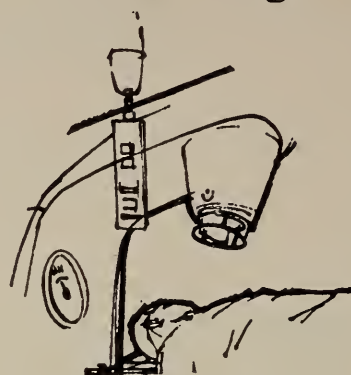
Table 2.

Findings	Blood lead level per 100 gm.				Total	
	59 or <	60-74	80-150	> 150		
Pica	53	44	40	19	156	31.2%
Loose plaster	58	43	39	10	150	30%
X-ray						
Bbd +	18	7	16	9	50	0.82%
Bones +	19	11	14	6	50	0.82%

Relationship of a history of pica and loose plaster or flaking paint in the home, and of positive x-ray findings to the preliminary blood lead level in the 490 children.

Table 2 shows the incidence of findings considered a lead to possible overt lead intoxication. A history of pica or of loose plaster and flaking paint in the home was obtained in about one-third of these. There were radio-opaque shadows in the intestin-

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

al tract and lead lines in the bones in less than 1 percent.

These children were not considered ill by their parents. Specific inquiry was made in the lead clinic for symptoms commonly present in lead intoxication. Table 3 shows the result of such inventory in relation to the preliminary blood lead level. It will be noted that even such symptoms as irritability, lethargy, ataxia, and convulsion could be elicited historically. Anemia considered a prominent evidence of lead intoxication was a fairly common complaint.

Table 3.

Symptoms	Mcg. per 100 Whole Blood				Total cases
	59 or <	60-79	80-149	> 150	
Anorexia	20	12	17	9	58
Constipation	6	1	5	3	15
Abd. pain	14	8	11	4	37
Vomiting	14	5	13	13	45
Anemia	12	7	8	6	33
Irritability	5	0	1	2	8
Lethargy	6	4	3	6	19
Convulsions	1	0	1	4	6
Ataxia	1	0	0	2	3
Asymptomatic	157	73	66	3	299
Symptomatic					191

Distribution of symptoms elicited upon specific inquiry with relationship to the initial blood lead level. Two hundred ninety-nine (61%) were in fact asymptomatic.

Table 4 is a resume of the disposition of these cases. Twenty four failed to keep their return appointment and could not be followed. Unfortunately, twenty-three of these had preliminary blood lead levels over 80 micrograms per hundred grams

whole blood. One hundred twenty seven of the children were admitted to the wards for de-leading therapy. Thirteen of these had levels below 60 microgram percent but mobilized lead after a single dose of EDTA in amounts considered indicative of high tissue stores.⁵ One hundred sixty-one were treated with intramuscular EDTA in five-day courses in the outpatient clinic. The remaining 178 were discharged without therapy.

Table 4.

Disposition	Blood lead level mcg. per 100 grams whole blood			
	<60	60-79	80-150	>150
Admitted to wards	13 (1.29%)	31 (26.2%)	64 (56%)	19 (70.3%)
Treated as outpatient	62 (26.8%)	67 (56.7%)	27 (23.6%)	5 (18.5%)
Discharged no therapy	155 (67 %)	20 (17.9%)	3 (2.6%)	0
Lost to followup	1	0	20 (17.5%)	3 (11 %)
Total	231	118	114	27

Disposition of the 490 children in relationship to their preliminary blood lead levels.

Discussion

The usefulness of a house to house canvas in the prevention and treatment of lead intoxication in the young child needs clarification. The procedure is laborious and the yield in cases requiring therapy relatively small. Jacobziner⁶ has shown that morbidity and mortality rates can be materially reduced in a great city by a case finding program. His procedure was to elicit pica as a clue to possible poisoning. This was done by careful history taking in health centers, and was checked by drawing blood levels in suspected children.

In the house to house canvas, the question of a screening test arises. When urine samples are collected and positive coproporphyrin found on qualitative laboratory analysis, a large number will later be found free of evidence of intoxication, or even a high body burden of lead. This is particularly true in Negro populations where sickle cell anemia is common. There are also many other causes for a positive qualitative coproporphyrin III in the urine. Furthermore, the interpretation of the test varies with individual laboratory technicians. Negative tests may be obtained in a fair proportion of children with overt lead intoxication.

Historically, pica and/or loose wall plas-

ter and flaking paint in the home is a good lead. In this series, it was elicited in about one-third of the children. A little over one-third of these had lead levels considered in the normal range. Some of the latter showed evidence of a high body burden of lead on stimulation with EDTA. We consider such at potential risk of overt symptomatology under the influence of summer heat and humidity or illness producing acidosis. X-ray examination yielded evidence of lead exposure in less than 1% of our survey children. It is an expensive and cumbersome procedure, so of little use in surveys such as this.

Chemical analysis of the blood for its lead content is the best method in case finding. Recently, analysis of the hair has been reported as a good source for determining lead storage.⁷ The method is technically difficult, however, and levels vary with the portion of hair analyzed, that is close to the root or tip, dependent upon the time of ingestion. For the present, this method must be considered experimental, but should be pursued. Storage also has been reported in deciduous teeth, but this has no practical value in surveys.

Kehoe^{8,9} has shown urine lead analysis to be unreliable in single random specimens, since excretion may be irregular over the 24-hour period. Furthermore, collection in lead free containers in an outpatient survey is practically impossible in this population group. It is difficult even with trained personnel in hospital wards where full twenty-four hour specimens are required. Blood lead analysis, therefore, is the critical method of screening. Here again there is often difficulty in extensive outpatient survey since procurement of specimens in lead-free containers and the availability of a reliable laboratory is so variable. At the Hektoen Research Institute of Cook County Hospital, there is a fine toxicology laboratory with analyses by expert chemical technicians using a modern Perkins-Elmer Absorption Spectrometer.¹⁰ Berman¹¹ has devised a method of quantitative lead analysis by micro technique of great potential value in surveys.

In this series of 812 children referred for possible therapy, 127 were admitted to the wards and 161 were given intramuscular EDTA on an out-patient basis. Thus, 288 (35.4%) were considered to have body burdens of lead high enough to require

therapy. This is about one child in three surveyed. The figure is impressive in view of the fact that 271 of those referred failed to report and 27 did not keep their follow-up appointments. With sufficient public health sanitarians to comb the neighborhoods in the lead belt, these figures can surely be greatly improved. Inspection of the premises, collection of specimens of flaking paint and cracked plaster for lead analyses, along with persistent cross-examination of the parents for possible pica can be of great aid in case finding. At the same time, they furnish the best method for an education campaign directed to the slum dweller.

During the period 1958-1965, 934 children with lead intoxication were admitted to the Cook County Children's Hospital. (Table 5). One hundred and sixty of these had lead encephalopathy of whom 63 (38.1%) expired. In 1966, the year of this survey, there were 182 admissions. Twenty-two of these (12%) had proven encephalopathy with three deaths, a fatality rate of 13.6%. These figures reflect improved

Table 5.

Years	Total Intoxications	Encephalopathy	Expired	Fatality Rate
1959-1965	934	160 (17%)	61	38.1%
1966-1967	182	22 (12%)	3	13.6%

Comparison of the total admissions for lead poisoning to the Cook County Hospital, Children's Division during 1959 through 1965 with 1966-67, the year of the neighborhood case finding program.

methods of therapy. The first group includes children subjected to extensive flap craniectomy,¹² a method we have since abandoned. It is true these figures are for a single hospital. In Chicago admissions of children with lead intoxication have been principally to the public hospital with only a scattering of cases to other university or community hospitals. In 1966, the survey year, considerable numbers were treated as out-patients. Of those hospitalized, many were early cases. All three of the children with fatal encephalopathy entered the hospital late and were severely ill with convulsions, coma, and apnea. Interestingly, one of these children had been referred to the hospital as a result of the case finding program. She developed convulsions the evening before her assigned appointment and was brought in as an emergency. These figures suggest the value of the neighborhood survey in bringing

children with high lead stores to therapy before the onset of encephalopathy.

The use of calcium disodium edetate on an out-patient basis poses an important problem. Unless the procedure is combined with immediate rehabilitation of the home, there is great danger that the child receiving a daily dose of EDTA will continue to ingest large quantities of lead paint with enhanced absorption from the intestinal tract. We have great reservations relative to the rapidity with which sanitarians can render homes safe in the large numbers of cases involved. We cannot document an instance of a treated child becoming ill with severe encephalopathy during or shortly after his course of out-patient injections. It is much safer, to separate the child from the poison. The hospitals beds available for such purpose in the asymptomatic child are practically non-existent in Chicago, either in the public or community hospitals. This would be true even if funds could be found to pay for in-patient care. This poses a dilemma which we have attempted to solve by close social service supervision and liaison with the Chicago Board of Health. Our own figures of an 11 percent loss to followup indicate the risk we are taking. We feel that it is the lesser of two evils, however, particularly in the light of the child who was given an appointment one week in advance and went in convulsions on the preceding night with exitus from lead encephalopathy.

It is still recognized that separation of the intoxicated child from the source of the poison is the primary step in his treatment. Where prevention is concerned, public health authorities in large cities like Chicago must devise an in-patient facility where children at risk may be de-lead.

Summary

1. A case finding survey aimed at detecting children in the one-to-five year age group at risk from lead intoxication is described.

2. Of 812 such children referred to the Division of Pediatrics, Cook County Hospital, Chicago, Illinois, 288 or a little over one third were considered to have body burdens of lead high enough to be benefited by therapy.

3. Qualitative determination of copro-

(Continued on page 650)

Neurologic Complications Of Oral Contraceptives

By C. M. MAYO, M.D., S. CHOKROVERTY, M.B.B.S., M.R.C.P., E.,

AND A. T. ORDINARIO, M.D.

A number of neurologic syndromes have been reported among women taking oral contraceptives. A causal relationship, however, has not been proven. It is the purpose of this paper to draw attention to an apparent association between the use of oral contraceptives and certain neurological syndromes.

In 1964, at the October meeting of the Academy of Ophthalmology and Otolaryngology, Walsh reported papilledema in a woman taking oral contraceptives. Such an occurrence had never been reported previously. For this reason, Cogan in an editorial in the *Archives of Ophthalmology* in 1965 asked doctors to report their cases to Dr. Walsh.¹ Following this editorial, Walsh was able to collect 69 cases which were subsequently published.² Until this report and that of Shafey and Scheinberg,³ little attention was paid to the neurologic disorders occurring in women taking oral contraceptives.

Walsh classified the neurologic syndromes associated with the oral contracep-

tives into four major groups. These are headaches, pseudotumor cerebri, vascular occlusive phenomena and retrobulbar neuritis. This classification will be adopted in the following discussion.

A. Headaches

Perhaps the most common, and fortunately the most benign syndrome, is the occurrence of headaches which are vascular in character. This kind of headache is throbbing, pulsating and is accompanied by nausea and vomiting. Focal neurologic signs such as blindness, homonymous field defects, and sensory or motor deficits may or may not co-exist with the headaches. They occur in paroxysms and are relieved by ergotamine preparations if given at the onset of the headache. Shafey and Scheinberg³ believe that there is evidence to imply a definite relationship between this type of headache and the ingestion of oral contraceptives. A total of 28 patients cited by the authors had headaches which abated after cessation of oral contraceptives. Walsh collected ten cases of migraine. Of the ten, three patients gave a history of migraine headaches before taking anti-pregnancy pills, and one had previous surgery for a ruptured intracranial aneurysm. All the patients who stopped taking the pills were relieved of their headaches. One patient who continued to take the contraceptive remained symptomatic. However, in a recent paper Gardner et al.⁴ pointed out that in some of their patients the headaches persisted despite the termination of the drug.

Undoubtedly, all patients having vascular headaches while on contraceptive pills are not reported. Nonetheless, we must be guarded in attributing etiologic relationship considering the paucity of reported cases. A careful follow-up of a large series of cases for a prolonged period is necessary before the pills can be incriminated in the causation of migrainous headaches.

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In the preparation of this treatise Drs. Mayo and Chokroverty were assisted by A. T. Ordinario, M.D., senior resident in the Neurology Service, Veterans Administration Hospital, Hines.

B. Pseudotumor cerebri or benign intracranial hypertension

This neurologic entity can best be defined as a syndrome of increased intracranial pressure without clouding of the sensorium or focal neurologic signs. The ventricles are normal or small as shown by air studies. Usually patients seek medical help because of headaches and vomiting. Papilledema is present; and if lumbar puncture is performed, elevated spinal fluid pressure is noted. There are no significant pathological changes. This condition is frequently found among young females.

Four such cases associated with oral contraceptives were reported by Walsh.² One case occurred a month after cessation of oral contraceptives. All subsequently improved after discontinuing the pill.

The occurrence of pseudotumor cerebri in the menarche and in patients having menstrual dysfunction suggests an endocrine relationship.^{5,6} This suggestion is further strengthened by reports of cases of benign intracranial hypertension following reduction in dosage or termination of prolonged cortico-steroid treatment.⁷ Greer⁷ believes that a state of subclinical adrenocortical insufficiency exists in these patients.

McKerns and Bell⁸ have shown that *in vitro* synthesis of cortisone is inhibited by estrogen. In view of the suggested deficiency of cortico-steroids in pseudotumor cerebri and the findings of McKerns and Bell, the following questions arise:

1. Do synthetic steroids, as contraceptive pills, inhibit the synthesis of adrenal cortical hormones?
2. Does the administration of adrenocortical hormones have any appreciable effect on benign intracranial hypertension?

These questions are presently unanswerable. Indeed, there are a few cases of benign intracranial hypertension that improve with cortico-steroid administration.⁷ However, when one considers the great frequency with which this disorder remits spontaneously, the definite role that steroids play remains in doubt. For this reason, considerable caution must be exercised in the interpretation of the causal relationship between oral contraceptives and pseudotumor cerebri. The dubiousness of this relationship is emphasized by the fact that

young females are more prone to develop the syndrome of benign intracranial hypertension.

C. Vascular occlusions

The possible relationship between peripheral thrombophlebitis and oral contraceptives has received much publicity recently. The Food and Drug Administration⁹ feels there is no increased incidence of thrombophlebitis in users of oral contraceptives. Nevertheless, the suspicion lingers that these pills may alter blood coagulation in some manner as yet undetermined. This same suspicion of hypercoagulability hovers over cases in which cerebrovascular accidents have occurred while patients were taking oral contraceptives. Thus far, no definite proof of hypercoagulability with these pills has been found. Results of experimental studies have been conflicting.

Egeberg and Owren¹⁰ have found an increase in Factor VIII (anti-hemophilic globulin) and slight increase in Factor VII. However, Donayre and Pincus¹¹ were unable to demonstrate an elevation of Factor VIII. In this respect, a case report by Haber¹² is worth mentioning. The patient had had frequent hemorrhages since the age of five for which she needed several blood transfusions. It was found that she lacked Factor X. Surprisingly, during pregnancy her hemorrhagic diathesis remitted and would recur in between pregnancies. On the basis of this observation, she was treated with norethynodrel. Her bleeding stopped. Therefore, at least on clinical grounds, there seems to have been an improvement in the clotting factors. Whether the oral contraceptives have any effects on the clotting factors in the normal female is debatable.

A few individual cases of cerebrovascular accidents occurring while the patient was taking oral contraceptives have been reported in the British literature.^{13,14,15} No really significant statistical analysis of these cases has been made. Cerebrovascular occlusive disease is relatively rare among women aged 20-40 years. In the past three years, however, an apparent increase in the incidence of cerebrovascular accidents among young women has been noted. The increasing use of oral contraceptives has been among the causes incriminated in this respect. In a recent paper Bickerstaff and Holmes¹⁶, from an analysis of all the pa-

tients referred to a particular Neurological Service, mentioned 25 cases of cerebrovascular occlusive disease in otherwise healthy women below the age of 45 during the period between 1964 and 1966. Eighteen of these patients had been taking oral contraceptives. On the otherhand, the number of such patients seen in the 10 years before 1964 was 25. Therefore, they cautiously warned that there may be an association between the oral contraceptives and cerebrovascular occlusive disease. In this connection it is noteworthy that in some of the patients reported by Gardner et al.⁴ the neurological symptoms continued to progress and terminated in completed "stroke" despite withdrawal of the drug. Of the 17 "strokes" noted in Walsh's collection,² three cases had hypertension, one had Raynaud's phenomenon, and one had a previous history of intermittent visual field defects. One patient in the group who developed strokes while taking oral contraceptives had what appeared to be homocystinuria. This patient, while taking contraceptive pills, developed multiple venous thrombi along with thrombosis of the superior sagittal sinus. Because one well-known feature of homocystinuria is vascular thrombosis, the relationship between the vascular thrombosis and the contraceptive in this case is extremely uncertain.

Several fatal cases of cerebrovascular disease occurring while taking oral contraceptives have been studied at autopsy. The cerebral vessels and areas of infarction found at autopsy differed in no way from the usual findings after an ordinary stroke. Experimentally, in rabbits, Danforth¹⁷ found abnormalities in the major arterial trunks in the animals given Enovid. These changes were similar to vascular changes found in pregnant rabbits. These changes included increase in the smooth muscle, fragmentation of reticulum, and loss of corrugation of the elastica. Perhaps a closer examination of the blood vessels rather than the clotting factors may give a better insight into the relationship between vascular occlusion and oral contraceptives.

D. Optic neuritis

There were eight cases of retrobulbar neuritis collected by Walsh;² of these, two subsequently developed full blown multiple sclerosis. The other six cases did not progress further, and a few recovered after

discontinuation of the pill.

The length of follow-up in all these cases is too short to allow a positive conclusion on the causal relationship. It is well known that retrobulbar neuritis spontaneously remits and in 40-50 percent of cases may progress to multiple sclerosis.¹⁸

Summary And Conclusions

Consideration of the four major categories of neurological disease associated with oral contraceptives does not allow of a definite conclusion concerning an etiologic relationship between any category and the medication. With approximately seven million young women taking oral contraceptives, the task of correlating the pill with diseases becomes almost impossible.

When millions of people have millions of headaches while taking millions of pills, only very rigid definitions and long term studies will support the clinical suspicion that vascular headaches are increased by the pill.

Pseudotumor cerebri and optic neuritis both naturally come and go regardless of treatment or apparent causes. Therefore, unless an overwhelming number of cases have been reported in women taking contraceptive pills, one cannot be certain about the relationship between these two syndromes and the oral contraceptives.

Vascular occlusive disease, because of its inherent disabling feature, demands a very close investigation. Great caution should be exercised in the administration of these drugs to women having a history of vascular headache, hypertension, diabetes or vasospastic disease. We believe that a comparative study regarding the incidence of cerebrovascular disease in females taking contraceptive pills and a control group should produce valid data that might clarify some of the problems raised in the preceding discussion.

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(Continued on page 636)



SUICIDE AMONG PHYSICIANS

The physician knows that death solves many problems, but he rarely stays with the family long enough to discover the ensuing problems when it is self-inflicted. This, and many other facets of suicide, came to light at the National Conference of Suicidology held recently in Chicago. Dr. Paul Blachly's report on 248 physician-suicides was of special interest because it strikes close to home. The highest incidence of suicide was among doctors in peripheral branches of medicine associated with chronic disorders. In these specialties, the physician may not feel that he is contributing as an individual. Many become moody and have problems with drugs or alcohol.

Suicide rates were highest for psychiatrists (61 per 100,000); ophthalmologists and otolaryngologists were next (55 per 100,000). The rate was lowest among pediatricians (10 per 100,000) followed by pathologists and surgeons with 25 per 100,000 apiece.

Dr. Blachly and his group found that 75 per cent of the physician-suicides were depressed or disturbed and approximately

40 per cent had prior psychiatric care. The largest number of suicides were related to disorientation, anxiety, egoism, or isolation.

The traits most rewarding to medical students may lead to suicide 10 to 20 years later. Many medical students are characterized by compulsive attention to detail, high aspirations, a boundless energy of hypomania, and prolonged deferral of gratification. Depression and anxiety begin when the physician has been in practice for several years but these traits fail to bring their fantasied rewards.

Interestingly enough, suicides occur with greater frequency among graduates of certain medical schools and from certain classes. In this category, the University of Illinois was in the upper five.

Many of the widows believed that self-inflicted death might have been prevented had she or her deceased spouse obtained assistance from the medical society. Some of the suicides knew each other or were treated by the same psychiatrists who, in turn, took their own lives.

T. R. Van Dellen, M.D.

Daniel Drake In Illinois

By LEO M. ZIMMERMAN, M.D./CHICAGO

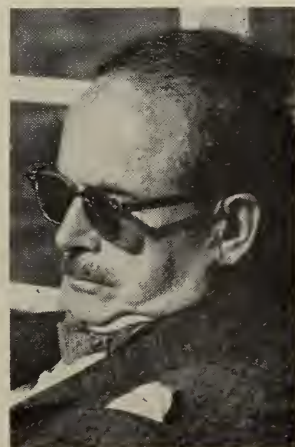
The history of medicine in the Midwest, including that of Illinois, begins with the work of the pioneer scientist, author and medical educator, Daniel Drake, whose rich and colorful career began just about the time that Illinois first became a state. Born in New Jersey, Drake was brought to Kentucky by his family when he was three years old; he grew up sharing the hardships and privations of pioneer life on a remote frontier farm. Despite the meager and primitive educational facilities, he aspired to become a doctor, in which ambition he was supported by his parents. Apprenticed to a physician in the small town of Cincinnati, Daniel learned by precept and reading what was then required of a country doctor. Not content with mediocrity, however, he attended medical school and received the first diploma issued west of the Allegheny Mountains. Spurred on by ambition and endowed with limitless drive, he became not only a successful physician, but the most important figure in the history of medicine of the West.

In addition to his medical practice and his effective participation in civic activities, his two major interests were medical education and the ecology of disease. New medical schools were spreading throughout

the states of Kentucky and Ohio and Drake began his career as a medical educator at these institutions. Frequently transferring from one school to another, some of which he was influential in starting, he struggled constantly for improvement of the teaching of medicine. This restless career, which included thirteen calls to new positions and nine professorships in five different medical schools, was surpassed in its importance only by his scientific endeavors.

Daniel Drake's greatest work was the study, in depth, of the geography, climate, social conditions, flora and fauna, and the population of the entire Mississippi Valley from the humid delta of Louisiana to the frozen North; and their relationship to the prevalent diseases. This self-imposed task to which he devoted thirty years of application culminated in his book, *A Systematic Treatise, Historical, Etiological and Practical on the Principal Diseases of the Interior Valley of North America, as they appear in the Caucasian, African, Indian and Esquimaux Varieties of the Population*. The first volume of this book was published in 1850, and the second, posthumously in 1854, two years after the author's death. This work is a magnificent contribution and one of the great treatises of all time on the relationship of environment

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to disease. Fielding Garrison, dean of American medical historians, said of this publication, "... There was nothing like this book in literature, unless it might be Hippocrates on Airs, Waters, and Places, and even Hippocrates made no attempt to triangulate the geographic locale of disease ..."¹

Space will allow for but a few brief excerpts from Drake's great work. Those quoted below were selected in order to give some idea of the depth and thoroughness of his studies. Also, they pertain essentially to Illinois, the sesquicentennial of which we are celebrating.

LOWER PART OF THE ILLINOIS RIVER—

In the month of September, 1844, about two months after the great flood, I ascended the Illinois River eighty-four miles, to Meredosia, and had an opportunity of observing that the deposits which it left on the surface of the broad bottom-lands, were agrillaceous, instead of being sandy, like those of the Missouri River, on the opposite side of the Mississippi. The grass and annual herbage, had been killed by the submersion. Of the trees, the white hickory (*Carya procina*) suffered most. This was an extraordinary flood; but the uncultivated state of the bottoms, generally, indicates that they are liable to annual inundation. On one side or the other of the trench through which the river flows, there is a bluff of sub-carboniferous limestone or Devonian sandstone rocks; on the opposite, a low, wooded bottom, abounding in extensive lagoons, ponds and swamps. There are, however, within the trench, many old and high diluvial terraces that are never overflowed.²

JACKSONVILLE—From the river to Jacksonville, twenty miles east of Meredosia, the road passes through Morgan County, one of the most populous of the state. The fertile surface is undulating and dry, and presents a continued series of groves and prairies. The strata beneath are composed of carboniferous limestone, and the water is hard. The site of Jacksonville is an elevated undulating prairie, around which, to the east and north, at the distance of a mile, a sluggish stream, with oak-timbered banks, winds its way to Mauvaiseterre Creek, a tributary of Illinois River. The settlement of this town was begun in the year 1825. It is the seat of the Illinois College, and of the State Institution for the education of the deaf and dumb. From Doctor Jones I learned, that all the forms of autumnal fever occur at this place. Malignant intermittents are rare—remit-tents, tending to a continued type, rather frequent.

Doctor Prosser informed me that the prevalence of these fevers is much less than formerly. Doctor Smith thought them not more frequent and fatal than he had seen them in the basin of Licking River, Kentucky. Doctor English found them more malignant than he had seen



them in the lower valley of the Great Kenawha, in Virginia. *On the whole, they prevail here in a mitigated degree, compared with the surrounding region generally, and thus conform to its, apparently, salubrious character.* (Italics ours.)³

SPRINGFIELD—The road from Jacksonville to Springfield—the capital of the State of Illinois—runs directly east, through Morgan and Sangamon counties. The distance is thirty-six miles. The country has an elevated aspect, is gently rolling, and presents groves and prairies in alternation, with a predominance of the latter. In some places, the surface is so wet as to require the roads to be thrown up in the middle; but not a pond nor marsh is to be seen on the whole route. Autumnal fever prevails, but not with such violence as to have prevented a very rapid settlement of the country, and its successful cultivation.⁴

CHICAGO, the commercial metropolis of Lake Michigan, stands on a low sand-plain, on the western side of the Lake, in N. Lat. 41° 51', and W. Lon. 87° 35'. The breadth of this flat along the lake is about four miles, whence it runs back ten or twelve miles to the River *Des Plaines*, an elementary branch of the Illinois, described in the last chapter. When the lake stood at a level only twenty feet higher than at present, its waters overspread this bed of alluvion, and a portion of them flowed down the Illinois. At this time it is a savanna, abounding in marshes and low sand-ridges; transversed by the river just mentioned on the west, and on the east by the north and south forks of Chicago River or Creek; which, flowing nearly parallel with the lake shore, and at a short distance from it, unite within it and form a short common trunk, which meanders through its center, to the lake. The water in this natural canal is twenty feet in depth, and rises and falls, from the force of the winds upon the lake, about two feet; a fluctuation which tends to carry away the filth which would otherwise accumulate on its margins, from the houses on each side, and from the vessels which seek it, as the only harbor of Chicago.⁵

The site of Chicago was occupied in early times by the French, but they never resided on it in large numbers. It was, by the American government, made a military post, and an Indian agency. (In the year 1831, the town itself was commenced; and at this time [1848], its population is near twenty thousand. The city is supplied with water from the lake, through a hydrant-system. A growth so rapid indicates its prospective importance, and entitles it to the regard of the medical topographer.) Situate on the eastern, or leeward margin of a wet or marshy plain of great extent, it would, in a southern climate, be classed with the sickliest localities. Let us inquire, then, into the extent of the countervailing influence of its latitude, which is nearly that of 42°.

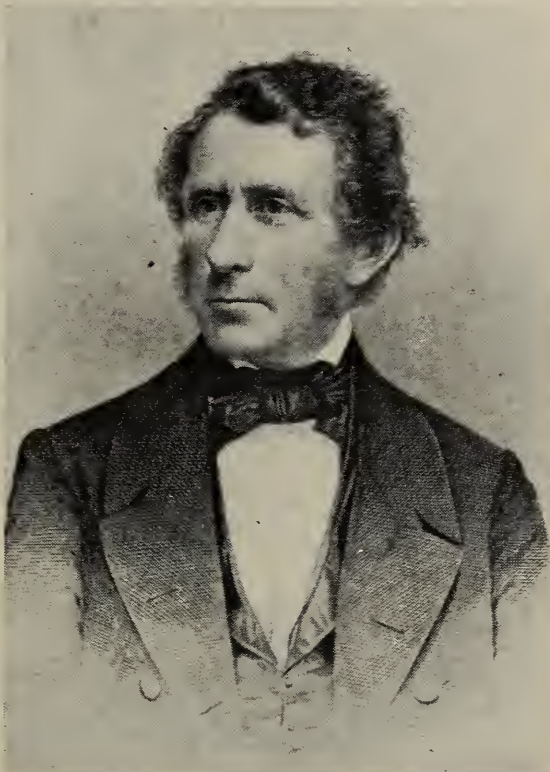
According to the returns from Fort Dearborn, for ten years, the annual ratio of its intermittents was twenty-three per cent,—that of its remittents, four per cent*. The annual ratio at Fort Wood, on the Gulf of Mexico, was, through the same period,—intermittents seventy-six,—remittents twenty-seven. These posts are about twelve degrees apart; and to this difference of latitude we may ascribe the different degrees of autumnal fever, experienced by their respective garrisons through the same period; a difference which may be expressed by saying, that while one hundred men would present but twenty-seven cases of fever at Fort Dearborn, the same number would present one hundred and three cases at Fort Wood.⁶

*Medical Statistics U.S.A., p. 87.

From Professor Brainard, of Rush Medical College, I received statements, which, when compared with those of the medical gentlemen of Green Bay, Milwaukee, and Racine indicate a decidedly greater prevalence of Autumnal fever in Chicago than in those towns; but he had not met with malignant cases. The accounts given me by Doctor Kimberly were less favorable than those of Professor Brainard. He spoke, particularly, of the year 1835, when the crowd of strangers was great, while the town-plat was still pondy or marshy, and a great deal of wet prairie was broken up with the plow. The statements of Doctors Boon, Davidson, and Brinkerhoff, fully sustained the impression made by the others, and convinced me that the town of Chicago has been more infested with autumnal fever than Fort Dearborn had been; which goes to strengthen the prevalent opinion, that the first exposure of the new soil to the sun, rain, and air is insalubrious.⁷

The second volume of Drake's great work deals with "The Principal Diseases of the Interior Valley of North America." A comparison of the prevailing illnesses of that day with those of today reveals the overwhelming frequency of endemic and epidemic febrile diseases in the earlier period. Several pages of the table of contents are devoted to the various "fevers." Little effort was made to differentiate the various diseases because of the lack of scientific

basis for the establishment of specific diagnoses. At best, one can recognize that most of them were malaria of various types. The term "intermittents" referred to those cases in which the temperature returned to normal between bouts of fever, as in the usual forms of malaria. "Remittents" were cases in which the temperature fell, but not to a normal level. "Autumnal Fevers" included all of the febrile illnesses occurring in the fall. The "typhous" fevers are listed separately, but little distinction is made be-



Daniel Drake

tween typhus and typhoid. In general, it was found that these fevers were far less prevalent in Indiana and Illinois than they were in Ohio.

From Drake's study, one gains the impression that health conditions in Illinois were relatively good as compared to other states. The autumnal fevers particularly, which appear to have been most severe and dangerous, were found to be infrequent here. Other evidence of a healthful environment which strongly influenced the pattern of settlement to the West can also be gleaned from the writings of Drake. We are told by his biographer⁸ that he wrote a paper on milk-sickness, based on his experience with it in Ohio, but he makes no mention of it in connection with Illinois. We know further that Nancy Hanks,

the gentle and beloved mother of Abraham Lincoln died of this sickness in Kentucky, as did several other members of the family. Unable to cope with this scourge, the family began their migrations which terminated in their settling and remaining in Illinois where they evidently escaped its ravages. Apropos of milk-sickness, Drake was perceptive enough to have convinced himself that the disease was due to the ingestion of poisonous plants by the cattle, which of course is now completely accepted. His error, however, was that he incriminated poison ivy rather than the Indian snakeroot which was actually responsible.

Further evidence of Drake's scientific acumen is evidenced in the following quotation:⁹ "In the year 1832, I published in the Western Medical and Physical Journal, of which I was an editor, . . . a series of papers on Epidemic Cholera . . . in which an attempt was made to show, that the mode in which that disease spreads, was more fully explained by the animaculae hypothesis than any other which has been expressed . . . Autumnal fevers and many of the other forms of disease might [also] be of animacular origin." He even attempted to visualize the organisms by mic-

roscopic examination. Unfortunately, and perhaps because of an inadequate instrument, he failed to find the organisms.

The work of Daniel Drake stands out as the most significant scientific contribution to have emerged from frontier America, not excepting the sensational contributions of Ephraim McDowell and William Beaumont. He not only laid the groundwork for an understanding of the health conditions and the illnesses of the vast central region of North America, but also established a standard of research in the relationship between environment and disease.

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THE VIEW BOX

(Continued from page 614)

Diagnosis

Pneumatosis intestinalis can no longer be considered a rare condition, there being over 400 case reports in the literature. It is clinically useful to divide these patients into two groups, primary and secondary. In the primary Pneumatosis intestinalis group, no other gastro-intestinal abnormalities are present, chiefly the colon is involved and most of the patients are adults. The secondary group of 85% is associated with a large variety of gastro-intestinal diseases including specific and non-specific chronic enteritis intestinal obstruction due to various causes, infantile diarrhea, necrotizing ileocolitis, and mesenteric vascular occlusion. Thus the presence of intramural gas, especially in the small intestine is not an entity per se, but a sign of an underlying disease or physiologic disturbance.

The pathogenesis of this condition has still not been satisfactorily explained but the prevalent theory is that increased intraluminal pressure allows the entry of gas through abrasion, ulceration or necrosis of the intestinal mucosa and then dissection into submucosal, subserosal, mesenteric or retroperitoneal tissue.

Roentgenographically, the primary type is usually manifested by multiple collections of small gas bubbles in either the subserosal or submucosal space or both. In the secondary type (our case) the gas distribution is invariably linear in character (note loops in the right lower quadrant). Pneumoperitoneum may occur with rupture of a serosal cyst. Gas may also be seen in the retroperitoneal space surrounding the kidneys.

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Inherent Faults in Government Medicine

BY ROBERT A. BEATTY, M.D./HINSDALE

Although modern medical science has brought increased health rewards, it has burdened us with increased financial worries. Rising medical costs render every family vulnerable to financial ruin if forced to draw exclusively from savings to pay for a prolonged illness. However, around the world alternative schemes have evolved which are designed to help the individual family meet its obligations with a little less apprehension. Some of these schemes are based on private motivated insurance programs; others are comprehensive nationally controlled programs, while still others are combinations of the two. At the present time medicine in our country falls into the last category but we are faced with the decision of whether to move further toward governmental control.

In making this decision we must ask ourselves several questions. First, under the present conditions is the working population being taken care of or could it be taken care of by private health insurance or alternative programs from the private sector? Secondly, has the non-working population, the aged and unemployed, been provided for adequately under the recent health legislation? Thirdly, what lessons can we learn by examining the experiences of countries who have already allowed their governments to manage their health care? The first two

questions can be answered only after we have more experience with the government sponsored programs. It is to the last question that I wish to direct our attention.

National Health Service of England

Fortunately, there are several schemes of government medicine available to examine which have existed long enough, perhaps, for us to make some valid conclusions. Probably the most centrally controlled and comprehensive plan is the National Health Service of England. My observations, although based on a year's employment in the NHS, are only observations, not statistically sampled facts but can, I think, serve as a lesson for our country.

The impending failure of the NHS has been widely publicized in the press, both lay and professional, but the emphasis has usually been on how the plan has been implemented. What has been ignored is that such a system has inherent faults in its basic philosophy which tend to encourage failure.

When the NHS began in 1948 its aim was to provide free comprehensive medical care from "cradle to grave" for the whole population regardless of income. It was to be financed by funds from the Exchequer, that is, taxes, and administered at the top by lay personnel. Central control was to be more economical because of buying in bulk and



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uniformly efficient operation. The Minister of Health, Aneurin Bevan, assured critics that politics and patronage would be no problem. The emphasis was to be on preventing disease because those people who formerly had avoided consulting physicians because of the expense would now come in earlier. The health of the population would improve, there would be a greater working force, and the country as a whole would benefit. Finally, physicians would be taken from the competitive world to practice medicine unimpeded by financial worries.

On paper such a plan appears to be the answer to everybody's problems. Why it has not fully succeeded, and is even tottering near collapse, is not too difficult to understand.

Central Planners Underestimate

The argument that central planning is more economical has been forcefully refuted by at least two tragic instances of underestimation. The economic planners believed that in time the cost of operating the program would level off after an initial increase. As the health of the nation improved, the demands on the Health Service would decrease. What they did not consider were the growth of the population, increased longevity, and most important, the increased demand for medical services as new developments in medicine appeared. The result of this was that the NHS was operating financially and psychologically at a deficit from its beginning.

A corollary of this was that for the first 10 years of its existence the NHS did not build a single new general hospital.¹ In effect, the government had acted as a monopoly by removing the incentives to private enterprise to stimulate growth. A rival system was not discouraged but it certainly was not encouraged.

Mistakes Have Grave Consequences

These errors in implementation are not the point I wish to make but, rather, that mistakes made on such a grand scale have grave consequences, affect large numbers of people, and are difficult to remedy. Had the mistakes been made on a regional level, other regions might have recognized them and embarked on other courses. Comparing alternatives is virtually impossible in a centrally governed system. Enoch Powell, the

Minister of Health from 1960 to 1963, recently has written that what exercises the anxiety of the medical profession is not the rightness or wrongness of the Minister's decisions but the uniform application of those decisions.²

He also observed that the universal Exchequer financing of the service endows everyone with a vested interest in denigrating it. The nebulous concept of the "Government" is far enough from the citizen's grasp that he offends no one when criticizing it. "Dissatisfaction with the service is endemic and inherent in the system,"² whereas a similar service, possibly even inferior, is an object of personal interest and pride when sponsored locally.

Political Overtones

The belief that the NHS would be free from political entanglements is a classic example of naive self-deception. From the beginning, whenever politicians have been entrusted with a program they have managed to give it political overtones. Regardless of how brilliant or how altruistic the politician, he is an amateur, politically motivated, and is no substitute for a professionally trained person.

With periodic changes in governments come changes in attitudes toward social programs which generate, usually, a healthy re-examination of the facts. However, when such re-examinations become political struggles, the citizenry, who in this instance have planned their lives around the NHS, become apprehensive about the future of their medical care. This insecurity is exactly what the system set out to prevent.

A more fundamental fault is that when economic or international crises involve a country, social programs are the first to be sacrificed. We have only to examine the reduction in our own "Great Society" program as a result of Viet Nam or the failed pay increases for English doctors during the present economic difficulties to verify this. The advisability of subjecting a nation's medical care to the unpredictable fortunes of the economy or international entanglements is surely open to question.

Disenchantment Growing

The success of the NHS depends on the co-operation of the nation's physicians and without it the whole structure would crumble. Significantly, the increase in emigrating

physicians suggests that disenchantment with the NHS is growing. Only the presence of Commonwealth doctors in the hospital service is preventing its collapse but even many of these men will eventually stop coming to England for their training as their own training programs expand.

What are the reasons for this growing disenchantment? Originally the NHS was to lift the physician above the sordid competitive world, away from economic worries. Almost immediately physicians were complaining about inadequate salary because the Government had made no provisions for wage increases as the cost of living increased. The idea to increase wages automatically as the cost of living increased was discarded because it was said to treat doctors as a privileged group. After promises by the Government and charges of bad faith from the medical profession, the Government granted a pay increase in 1952. This satisfied the medical profession for awhile until the whole disagreeable process began again. This points out another inherent fault in the governmental system which will continue to do exactly what it was supposed to prevent, namely, force the doctor to bargain periodically for economic security, thus diverting his attention from his primary purpose. The doctor assumes a labor union attitude which dominates his thinking and presents a not very admirable appearance to the public. How this affects his status and effectiveness in the community or the desirability of his profession for young men choosing careers can only be conjectured.

NHS Creates Artificial Society

The original aim of taking physicians out of the competitive world should be challenged. An artificial society which the NHS has created by rewarding its employees, in general, for longevity rather than ability has unfairly forced able young physicians to work as residents often into their late thirties until a consultant post is available through death, retirement, or a move. This artificiality is not unique to the NHS but, rather, is an inherent weakness of any civil service. However, here it is a greater problem because incompetence is more difficult to uncover, and when uncovered more difficult to deal with.

The system of merit awards for distinguished consultant physicians is commendable but is no substitute for healthy competi-

tion. It should act as an incentive for the physicians but one suspects that too often the incentives are political rather than medical.

The less ambitious or qualified physicians, on the other hand, are guaranteed an adequate living for life so long as they stay within the rather loose terms of employment. Consequently, the program lacks sufficient incentives and rewards which inevitably leads to dissatisfaction and perhaps, mediocrity.

Hospital Waiting Lists

How has the patient fared under this system? Originally, the emphasis was to be on preventing illness by encouraging earlier visits to the physician. Exactly the opposite has happened. The long waiting list for admission to the hospital has become a way of life, due partly to inadequate numbers of physicians and hospital beds, and partly to what Enoch Powell has described as the unlimited demand for medical care.² Rather than allow the laws of supply and demand to operate, the Government has attempted to control the demand by limiting the supply. The solution is a form of rationing, the waiting list, a solution Americans should not have to accept.

It is true that the medical care is free, but, as one writer has said, free at the time.³ Eventually, the taxpayer pays, and at a rate comparable to private health insurance premiums. Importantly, in the mean time he has deluded himself that it is free while, in some cases, over using it because he does not know its value. In essence, the latent irresponsibility present in all of us is encouraged.

Utilitarian Approach

The quality of care given to a hospitalized patient in the NHS is generally quite good, but by necessity the doctor assumes a utilitarian approach because of the number of patients he is expected to care for. The absence of the unwritten contract between doctor and patient seen in private medicine alters the attitudes of both parties so that some of the art of medicine is lost, some of the individual attention and mutual regard that Americans have always expected.

Privacy is a commodity which is becoming more scarce in this ever-shrinking world

(Continued on page 642)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Winnebago Doctors Polled on Public- Aid Fees

A poll by Winnebago County Medical Society found 60 members approving and 33 disapproving Illinois Department of Public Aid concepts of usual, customary and reasonable fees. Major areas of complaint were payments for injections, immunizations and antibiotics, and the "time-consuming, repetitive" forms, said Don Westbrook, the society's executive administrator. However, 47 members rated the overall arrangements with IDPA as better than in the past, while 32 regarded them as similar and 13 as worse. Eight members listed payments as taking an average of 30 days, 32 as 60 days, 19 as 90 days, and 26 as 120 days. Fifteen said IDPA headquarters in Springfield did not answer their correspondence, while 49 described the replies as slow and 15 as prompt. The society mailed questionnaires to 261 members.

Emergency Merger Sought in Cities Under 50,000

A resolution before the 1968 ISMS House of Delegates, May 19-22, will recommend consolidation of hospital emergency rooms in cities with less than 50,000 population. It asks ISMS to seek amendment of the Hospital Licensure Act to permit a single facility. The resolution, presented by Jackson County Medical Society, asserts that duplicate emergency rooms in small cities is "a waste of medical resources and manpower."

One of Seven Doctors Sued for Malpractice

One of seven American physicians is sued on malpractice charges at some time in his career, Frank M. Pfeifer, ISMS legal counsel, told an ISMS district conference in Springfield. The mounting number of suits, he said, reflects a drive for easy compensation in many areas of American life. ISMS will sponsor a malpractice-insurance program designed to create a proper legal climate as well as offer attractive premium rates and eliminate arbitrary cancellations. As soon as the plan is available, an announcement will be made to all members by mail and through the Illinois Medical Journal.

Federal Funds Sought For Teaching-Hospital Staffs

Some hospital elements have urged use of federal funds to pay organized staffs of teaching hospitals for public-aid care. They want the Illinois Department of Public Aid to make such payments on a collective basis. The ISMS Medical Advisory Committee to IDPA agreed to study the

(Continued on page 634)

Rx For A Happy Retirement:

"The Time Of Your Life"

ISMS-Blue Shield Retirement Planning Series Gets Under Way in May

A new "prescription" for happy, secure retirement is being offered by ISMS and Blue Shield with their new pre-retirement television series which began May 1 over WTTW, Channel 11, Chicago.

The 13-part series—presented by ISMS, its Committee on Aging, and Blue Shield Plan of Illinois Medical Service—is scheduled for 9 p.m. every Wednesday through July 24.

Later this year, tapes of the series will be distributed to television stations throughout Illinois. Films of it will also be made available to small industries, clubs and businesses.

Features Norman Ross

Featured on the series is broadcast personality Norman Ross, who each week will interview different guest experts on subjects essential to achieving a happy retirement. Discussions, supported by graphic demonstrations, will cover such topics as: financial planning for retirement years; meeting medical expenses; conserving the estate and making a will; living accommodations; and the physical, spiritual and emotional problems of the retiree.

Emphasizing the importance of the series, Dr. Bertram B. Moss, ISMS Committee on Aging chairman, said that "all too few of



"TAPE RUNNING"—Floorman, extreme left, stands by to signal start of show #2, on financial planning. Seated clockwise from left to right are host Norman Ross and guests William Dillon, senior vice president, American National Bank and Trust Company; and John C. Mannion, chairman of the board of Blue Cross and senior vice president, Continental Ill. National Bank and Trust Co.



SCRIPT CONFERENCE—Before program, last minute script changes are made by director Lou Abraham (left), host Norman Ross (center), and Dr. Bertram B. Moss, ISMS Committee on Aging Chairman. "Secret of series' success was that everyone from cameraman to producer got into the spirit and worked hard to make it interesting as well as informative," Dr. Moss said.

today's pre-retirees are prepared to meet the vast challenges that face them when they retire. Unless they prepare now, their inability to lead a constructive, balanced life or handle their finances properly can lead to untimely debility, as well as unwanted and unnecessary dependence."

Underlining Dr. Moss' comments, Walter Livingston, assistant vice president and director of professional services for Blue Shield Plan of Illinois medical service, added, "We are the first generation facing this new fact of life: earlier retirement and longer life. Within the next 30 years, one of every three Americans will be retired and can expect to live a full generation in retirement. Planning in advance as far as

possible is essential to making this protracted retirement successful."

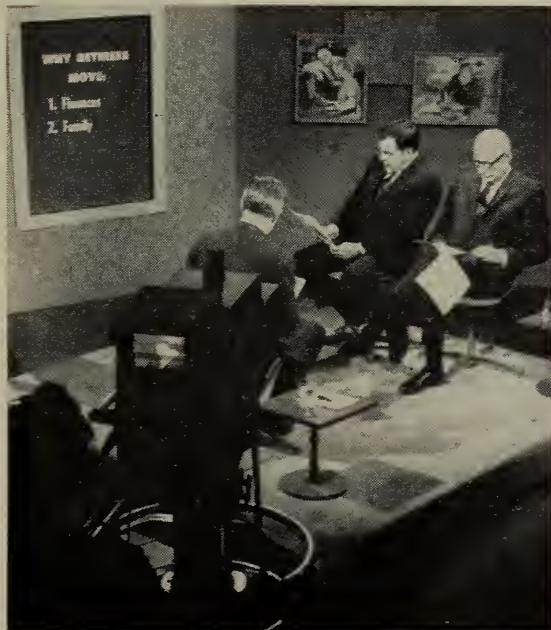
Urge Physicians to Watch

Dr. Moss asked that all Chicago area physicians not only watch the series, but ask their family, friends and patients to do the same. He also urged downstate physicians to request scheduling of the series by their local television stations. All inquiries should be directed to: Division of Public Relations, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

"The series now makes it economically feasible for virtually every segment of our population to receive pre-retirement training," Dr. Moss said.



CAMERA CATCHES LIGHTER MOMENT on show #5, on living accommodations for the retiree. Facing host Norman Ross are James Boomgard, Jr., principal of the Friends Fellowship Community, Inc., Richmond, Indiana, and Arthur Mohl, president, Downs, Mohl and Co. Realtors, Chicago.



REAR SCREEN "BLACKBOARD" lists reasons people move as guests discuss subject. "Our format is a completely new breakthrough in TV teaching films," proclaims Dr. Moss. "Conversation is informal and entertaining, but supported by visual aids to help viewers remember the advice being given."

CUE FROM DIRECTOR'S BOOTH is noted by Dr. Moss, standing center, as Norman Ross looks for appropriate spot in script.



proposal, but with the idea that any such fees should go directly to the individual doctor performing the service "rather than into a slush fund benefitting a third party." Under present department policy, fees are handled on this individual-performance basis and are not paid to full-time staff physicians.

IDPA Gives Factual Picture of Aid Recipients

The Illinois Department of Public Aid has statistically profiled the adult recipient of aid to dependent children. Only 30 per cent of the adults in the ADC combined program last June were high school graduates; 70 per cent had finished elementary school. Twenty-three per cent had no work experience . . . 42 percent were experienced in service occupations, 13 per cent in laboring jobs, 11 per cent in semi-skilled jobs, and the remaining 11 per cent in skilled, clerical and sales trades. Almost three-fourths of the families were nonwhite. Average age of 3,000 unemployed fathers in the ADC regular program was 39.

DuPage Doctors Propose Medical School Subsidy

DuPage County Medical Society is asking ISMS to sponsor a bill providing a per-student subsidy to all Illinois medical schools. The resolution to be considered by the ISMS House of Delegates May 19-22 said such a subsidy has worked advantageously in Pennsylvania for many years, "with a relatively high retention of the graduating physicians within the state regardless of their originating home state." Citing proposals for a sixth medical school in Illinois, the resolution said, "The costs of building a new school are much higher than the cost of supporting and enlarging a presently operating school."

Illinois One of 37 Medicaid States

The Federal Government announced that 37 states, including Illinois, now provide Medicaid (Title 19) assistance to welfare recipients and low-income families. Kansas, Nevada, Missouri, New Hampshire and Oregon recently qualified; South Carolina and the District of Columbia were expected to enroll shortly.

Chicago Teen-Agers Need 320,000 Summer Jobs

Here's a word for physicians who have children, or have summer chores to be done. Some 320,000 Chicagoans aged 16 to 19 will want work this summer, says the U. S. Bureau of Labor Statistics. This is 50,000 more than were employed in the warm months of 1967.

—By DON B. FREEMAN

Of the 447,600 veterans who trained under the G. I. Bill in fiscal year 1967, 72 per cent enrolled in colleges, four out of five as undergraduate students and one-fifth as graduate students working on advanced degrees, according to the Veterans Administration.

Discharged servicemen have 120 days to convert their Servicemen's Group Life Insurance policies to private insurance through any of more than 560 private insurance companies which participate in the program.

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Theodore G. Klumpp, M.D., president of Winthrop Laboratories, receiving a special citation from Newton DuPuy, M.D., president of the Illinois State Medical Society, for his contributions to "medicine, pharmacy and government service." Occasion was a reception held by ISMS and the Illinois Medical Journal March 6 in New York for advertisers and advertising agency representatives. Dr. George F. Lull, ISMS executive administrator (right), was master of ceremonies. Dr. Klumpp, who recently completed his 26th year as president of Winthrop Laboratories, has served on many governmental commissions concerned with health, particularly in the fields of cardiovascular diseases, vocational rehabilitation of handicapped persons and problems of aging.

Oral Contraceptives Complications

(Continued from page 621)

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ing hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs). **Outpatient Adult Dosage:** Initially, 75 mg. daily, increased, if necessary,

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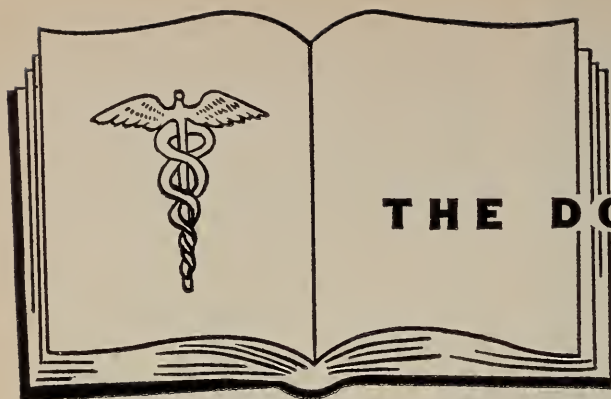
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THE DOCTOR'S LIBRARY

GYNECOLOGIC PATHOLOGY. Frederick T. Kraus, M.D. The C. V. Mosby Company, Saint Louis, 1967. 504 pages, 488 illustrations, \$18.50.

This volume on Gynecologic Pathology by Dr. Kraus is a well organized and well written book. It is divided into eleven chapters starting with the genesis and dysgenesis of the female genital tract, including cytogenetics, and ending with a chapter on the placenta. The usual format employed in the discussion of the various lesions is a short introduction to the subject, the pathologic features, the clinicopathologic correlation and comments on etiology, use of diagnostic procedures and treat-

ment where applicable. Emphasis is laid on the more common lesions, although the rare ones are likewise mentioned.

The selection as well as the quality of the gross and microscopic illustrations are excellent. The electron micrographs are of good quality. The other admirable point about this book is that the bibliography is extensive and up-to-date, thereby making it more convenient for the reader to pursue a subject in depth.

This volume will undoubtedly aid the gynecologist as well as the pathologist in understanding the background of diseases of the female genital tract. Residents in both specialties will likewise profit from reading this book.

PAUL B. PUTONG, M.D.

Government Medicine Faults

(Continued from page 629)

but in a public oriented system like the NHS it is actively discouraged. Because of nursing shortages and economy, hospitals are built on the large ward or glass partition plan so that more patients can be observed by fewer people situated at a central point. It is a relatively efficient system and, in fact, probably the only justifiable way to use public funds. However, patients are expected to bathe, take care of bodily functions, receive visitors, sometimes even to die separated from their neighbors only by a screen—a practice many Americans would find repugnant.

Some might argue that Americans value privacy, amenities, and personal attention more than skillful medical care, especially when they are purchased rather than received gratis. There probably is an element of snobbery active here which is unhealthy when it replaces sound judgment, but the fact remains that these ancillary aspects of medical care are often just as important as drugs and surgery. They should not be

dropped from our armamentarium for reasons of economy or because they are not life saving measures.

In summary, medical care financed and administered by a central government is placed at a disadvantage from its inception because of inherent faults in its philosophy which cannot be overcome by any amount of money or administrative ingenuity. We look to the advocates of government medicine to convince us they can overcome these faults.

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Average daily patient load at Veterans Administration Hospitals during fiscal year 1967 exceeded 114,000. During the same period, VA's 72 outpatient clinics received more than five million visits.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

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Because of the properties of propylene glycol and the milligram potency of fluocinolone acetonide, a small quantity of Synalar Solution goes a long way. Also, the prescription price of a 20 cc. plastic squeeze bottle of Synalar Solution is surprisingly low. Thus, your patients obtain economy with the proved efficacy of a potent, truly advanced topical corticosteroid.



Clinics for Crippled Children

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 5, Carmi—Carmi Township Hospital

June 5, Hinsdale—Hinsdale Sanitarium

June 6, Effingham General—St. Anthony Memorial Hospital

June 6, Lake County Cardiac—Victory Memorial Hospital

June 11, East St. Louis—Christian Welfare Hospital

June 11, Peoria General—Children's Hospital

June 12, Champaign-Urbana—McKinley

Hospital

June 12, Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital

June 13, Rockford—St. Anthony's Hospital

June 13, Macomb—McDonough District Hospital

June 13, Springfield General—St. John's Hospital

June 14, Chicago Heights Cardiac—St. James Hospital

June 14, Evanston—St. Francis Hospital

June 19, Chicago Heights General—St. James Hospital

June 20, Bloomington—St. Joseph's Hospital

June 20, Elmhurst Cardiac—Memorial Hospital of DuPage County

June 25, Belleville—St. Elizabeth's Hospital

June 25, Peoria General—Children's Hospital

June 26, Springfield Cerebral Palsy (P.M.)—Diocesan Center

June 26, Aurora—Copley Memorial Hospital

June 27, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

June 28, Chicago Heights Cardiac—St. James Hospital

Childhood Lead Intoxication

(Continued from page 618)

porphyrin III in the urine as a screening test in case finding is extremely inefficient. A history of pica in such children residing in deteriorated housing in the "lead belt" is more rewarding.

4. In the eight year period immediately preceding the year of this neighborhood survey, 160 children were treated for lead encephalopathy with 61 deaths, a case fatality rate of 38.1%. During the survey year, there were 22 admissions for lead encephalopathy with 3 deaths, a fatality rate of 13.6%.

5. One hundred sixty-four children were treated as out-patients with a daily intramuscular injection of calcium disodium edetate in a five-day course. The risk of this procedure was recognized. We were unable to document a single instance of aggravated lead intoxication in this group. Some method of separation of such children from their source of lead is recommended.

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ENDURON[®] ENDURONYL[®]

METHYLCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symptomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON[™] Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, deserpidine, nortriptyline or their analogues; other monoamine oxidase inhib-

itors; methyl dopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions —Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.



TM-TRADEMARK

for May, 1968

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To Better Understand Your Jewish Patient

By RABBI EPHRAIM H. PROMBAUM, B.A., M.H.L., D.H.L.

To better understand his Jewish patient the physician should realize that his patient is sensitive, is proud to be a member of one of the major religions of the World, but in the United States he is also a member of a political and social minority group. Within him then there is a conflict, between his reaction as a member of a major religious group and his need to recognize and accept the limitations of one belonging to a minority group.

The minority status of the Jew has already given him a sensitivity toward his historic origin. In a "Public" situation, such as being a patient in a hospital, the Jew may be too anxious to conform and may hide much of his Jewish feelings. In the privacy of the physician's office the opposite reaction may be manifested and the patient dwell on feelings and happenings relevant to his religion. In either extreme the physician should adjust his therapeutic method to the personal equation of the patient. A study of his religious background is perhaps the best source of information.

Frequently, the patient will reveal aspects of Judaism that have influenced him the most. The physician may be able to use this information to better understand his patient. Often a Rabbi or Jewish hospital chaplain will be of aid. The Jewish clergy of all denominations will consider it an honor to assist physicians in the care of their patients.

In the Old Testament, in ancient rabbinic literature (including The Talmud, legal and legendary books) and in later rabbinic literature there is a great deal about the history and practice of medicine. Much medical information has also come to the Jewish layman through religious dietetics and hygiene practices. Being aware of the medical prejudices found in the Jewish literature and those transmitted through religious practices will materially

assist the physician in attending his Jewish patient.

That the Jewish clergy have always respected the physician and tried to assist him is exemplified in the ancient teachings of Ben Sira (Ecclesiasticus, Chapter 38) "Honor a physician according to thy need of him—Him also hath God apportioned—"

"The skill of a physician lifteth up his head, and he may stand before nobles."

"My son, in sickness be not negligent; pray unto God, for he healeth. And also to the physician give a place. For he, too, maketh supplication to God, that He should prosper to him the treatment, and the healing, for the sake of his living."

Computerized Patient

(Continued from page 613)

the "computerized patient." A student types his request for information or his therapeutic invention, using his own words. If the information he seeks was originally programmed into the computer, he will receive a reply in a matter of seconds. Replies are typed, but other kinds of additional data needed for diagnosis and treatment may be provided.

If the student requests a physical examination of the heart, he will receive heart sounds through a stethophone. If he requests x-rays, electro-cardiograms or tissue biopsies, these will be projected on a screen adjacent to the keyboard.

The five computer facility to be installed and made functional by this grant from the Public Health Service will enable the college to enlarge upon its preliminary research and testing to make the "simulated clinical encounter" much broader in scope and a more efficient, effective and rapid instructional tool for medical education.

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Opinions and Reports on Ethical Relations

PHYSICIANS SHOULD RENDER SEPARATE BILLS

In many cases insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical, and all insurance plans which do not pay the individual physician in this manner should be urged to do so.

The Judicial Council is still of the opinion that, when two or more physicians actually and in person render service to one patient, they should render separate bills. There are cases, however, in which the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur, it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fees charged should be paid directly to the individual physicians who rendered the services in question. (House of Delegates, 1954)

ITEMIZED BILL

Nothing in the Principles of Medical Ethics proscribes the submission of an itemized bill by a physician to his own patient for medical service he actually rendered to the patient. (Judicial Council, 1957)

COMBINED OR JOINT BILLS

The Judicial Council has stated repeatedly (in its June 1954 Special Report and its December 1952 Annual Report, to cite two occasions) that, when two or more physicians actually and in person render service to one patient, they should render separate bills. The Special Report of June, 1954 indicates two exceptions to this general rule, namely, when a patient requests a single bill or when an insurance company demands one. The Council has insisted, however, that these instances are to be recognized as exceptional cases and not routine. (Judicial Council 1957)

SEPARATE BILL FROM ANESTHESIOLOGIST

Medicine has always insisted that anes-

thesia is a medical service, which should be administered by a licensed, trained physician or by another adequately trained person who acts under the direction and supervision of a physician who assumes responsibility for the medical service rendered. A physician properly should present a bill for the services he renders to the patient. (Judicial Council, 1957)

SURGICAL ASSISTANT'S FEE

The House of Delegates adopted the following five principles:

1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a fee may be ethically paid or received.

4. When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

5. It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether or not the assisting physician is the referring doctor. (House of Delegates, 1962)

FEE CONTINGENT ON OUTCOME OF LITIGATION

The Principles of Medical Ethics (Chapter I, Section 6, 1955 edition) provided that remuneration received for professional services rendered the patient should be in the form and amount specifically announced to the patient at the time the service is rendered, or in the form of a subsequent statement. It is the opinion of the Judicial Council that the contracting for, or acceptance of, a contingent fee by a doctor, which is based on the outcome of litigation, whether settled or adjudicated, is unethical. The Judicial Council would

point out that the laborer is worthy of his hire and that the physician, having only his services to sell, has an obligation to place a fair value on those services. Ethically this value should be based upon the value of the service rendered by the physician to the patient and not upon the uncertain outcome of a contingency that does not in any way relate to the value of the service. Furthermore, the Council is of the opinion that the physician's obligation to uphold the dignity and honor of his profession precludes him from entering into an arrangement of this nature because, if a fee is contingent upon the successful outcome of a claim, there is the ever-present danger that the physician may become less of a healer and more of an advocate—a situation that does not uphold the dignity of the profession of medicine. (Judicial Council, 1955)

BILLING PROCEDURE FOR LABORATORY SERVICES

1. The practice of pathology is an integral part of the practice of medicine,
2. All physicians should bill their patients directly, and
3. In exceptional cases, when it is not

possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services. (Judicial Council, 1965)

COOPERATIVE DIAGNOSTIC LABORATORIES

Concerns known as "cooperative diagnostic laboratories" have been organized in which practicing physicians participate as "members." Information indicates that organization is effected in such a manner that control will lie in the hands of the promoters and directors of these schemes and that practicing physicians are then expected to refer work to the laboratories operated by the concern. As a consideration for such referrals, the physician members receive from the laboratories compensation varying with the amount of work referred. The Judicial Council is of the opinion that schemes of this kind are unethical and directly opposed to the interest of scientific medicine. (House of Delegates, 1930)

Mental Illness Still Costs U.S. \$20 Billion Yearly

Despite steady improvement in treatment services, mental illness cost U.S. citizens more than \$20 billion in 1966.

Figures reported by Dr. Stanley F. Yolles, Director of the National Institute of Mental Health, show that mental illness cost Americans an average of almost \$48 each that year.

Commenting on the NIMH study, Wilbur J. Cohen, new Secretary of the Department of Health, Education, and Welfare, which includes NIMH, said the costs would have been even higher had it not been for many improvements in mental health services across the country.

"One of the department's major priorities is to increase knowledge and manpower and improve treatment services in mental health," Mr. Cohen said, "and our efforts are paying off as shown by the latest survey of the number of resident patients in state and county mental hospitals."

The Secretary added that last year saw the sharpest decrease in resident patients in such

hospitals since the downward trend began 12 years ago. He cited a 26,000-patient decrease which amounts to 5.8 percent for the year.

"Latest statistics show that as of June 30, 1967, there were 426,009 resident patients in state and county mental hospitals; 133,000 less than 12 years ago," Mr. Cohen said.

Management of Pain

(Continued from page 601)

traumatic neuralgia and of other distressing pains not due to cancer is encouraging.

4. The bilateral procedure entails risk of bladder function and in some instances of respiratory function. It should be avoided in all but exceptional cases. This means that most spinal, perineal, and abdominal pains are, at the present time, unsuited for this form of treatment. Efforts are being made to eliminate these risks so that in time these forms of pain may also be relieved.

Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093 —Telephone (312) 446-8440.

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

HYDREA Cancer Chemotherapy R

Manufacturer: E. R. Squibb & Sons

Nonproprietary Name: Hydroxyurea

Indications: Melanoma and resistant chronic myelocytic leukemia.

Contraindications: Marked bone marrow depression; women of childbearing age.

Dosage: Intermittent therapy: 80 mg./Kg., orally as single dose, every third day.

Continuous therapy: 20-30 mg./Kg., orally as single dose, every day.

Dosage based on patient's actual or ideal weight, whichever is less.

Supplied: Capsules—500 mg., bottles of 100.

DUPLICATE SINGLE PRODUCTS

LUBRICORT Corticoid—Local R

Manufacturer: Texas Pharmacal Co.

Nonproprietary Name: Hydrocortisone

Indications: Pruritic dermatoses accompanying physiologic dry skin conditions, and corticosteroid responsive dermatoses.

Contraindications: Tuberculous, fungal, and most active viral diseases of the skin. Not for cutaneous manifestations of such diseases as pemphigus or lupus erythematosus. Not for ophthalmic use.

Dosage: Apply topically 3 or 4 times daily.

Supplied: Cream— $\frac{1}{8}\%$, $\frac{1}{4}\%$, $\frac{1}{2}\%$, and 1%, tubes or jars of $\frac{1}{2}$ to 4 oz.

Lotion—same strength as cream, bottles of 2 to 8 oz.

MANNITOL I. V. Diuretic—Other R

Manufacturer: Abbott Laboratories

Nonproprietary Name: Mannitol

Indications: Oliguric phase of acute renal failure, pre- and post-operative reduction of intraocular pressure in surgical management of glaucoma, and as an adjunct to eye surgery in non-glaucomatous patients.

Contraindications: Advanced renal failure, severe congestive heart failure and pulmonary edema, metabolic edema associated with increased capillary fragility or membrane permeability, patients with head injury where possibility of intracranial bleeding exists.

Dosage: Adults—50 to 200 Gm/24 hrs., i.v.

Supplied: Solution—5% and 10%, bottles of 1,000 cc. 15%, bottles of 500 cc.

SOMNAFAC Hypnotic—Non-barbiturate R
Manufacturer: Smith, Miller & Patch, Inc.
Nonproprietary Name: Methaqualone HC1
Indications: Insomnia

Contraindications: Pregnancy, in conjunction with psychotropic drugs or other central nervous system depressants, in children under 14 yrs. of age.

Dosage: One or two capsules 15-30 minutes before retiring.

Supplied: Capsules—200 mg., bottles of 100.

TYPHOID VACCINE Biological R
Manufacturer: Wyeth Laboratories

Nonproprietary Name: Salmonella typhi organisms, killed

Indications: Active immunization against typhoid fever.

Contraindications: None mentioned.

Dosage: Primary immunization:

Adults and children over 10 yrs.—two doses of 0.5 cc. each, s.c., at interval of 4 or more weeks.

Children 6 mos. to 10 yrs.—

two doses of 0.25 cc. each, s.c., at interval of 4 or more weeks.

Booster doses:

Single doses in same range as above.

Supplied: Vials—5, 10, and 20cc. (1 billion organisms/cc.)

COMBINATION PRODUCTS

AMCORT CREAM Antibiotics—Topical R
Manufacturer: Texas Pharmacal Co.

Composition: Each gram contains:

Amphotycin calcium 5 mg. base

Neomycin sulfate 3.3 mg. base

Hydrocortisone acetate 10 mg.

Indications: Primary and secondary cutaneous

infections caused by organisms susceptible to amphotycin or neomycin.

Contraindications: Cutaneous manifestations of pemphigus or lupus erythematosus, tuberculosis of the skin, cutaneous infections of viral origin, fungal lesions, hypersensitivity to any of the components.

Dosage: Apply topically three times daily.

Supplied: Tubes—15 grams.

COLREX DECONGESTANT Cold Prep. R
Manufacturer: Rowell Laboratories

Composition: Chlorpheniramine maleate 4 mg.
Triphenylamine HC1 50 mg.
Phenylpropanolamine HC1 25 mg.
Phenylephrine HC1 10 mg.

Indications: Symptoms of allergic rhinitis, sinusitis, hay fever, and colds.

Contraindications: Not for children under 6 yrs.

Dosage: Adults and children over 12 yrs.—

one tab. 3-4 times daily.

Children 6 to 12 yrs.—½ tab. 3-4 times daily.

Supplied: Tablets—bottles of 100, 1,000, and 5,000.

COLREX EXPECTORANT Cough Prep. O-t-c
Manufacturer: Rowell Laboratories

Composition: Each 5 cc. contains:

Glycerol guaiacolate 100 mg.

Ammonium chloride 100 mg.

Indications: Bronchitis, asthma, bronchiectasis, colds.

Contraindications: None mentioned.

Dosage: Adults and children over 12 yrs.—two tsp. q4h.

Children 6 to 12 yrs.—one tsp. q4h.

Children 1 to 6 yrs.—½ tsp. q4h.

Supplied: Syrup, sugar-free—bottles of 4 and 16 oz.

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MEETING MEMOS

June 9-13—The 1967 Annual Meeting of the Medical Library Association will be held at the Brown Palace Hotel, Denver, Colo.

June 13-17—The San Francisco Hilton Hotel will be the site of the 34th Annual Meeting of the American College of Chest Physicians. There will be scientific sessions, workshops, research forums and post-graduate seminars.

June 15—The American Association for the Study of Headache will conduct its 10th Annual Meeting at the St. Francis Hotel, San Francisco, Calif. Four sessions will point up progress being made in the study and treatment of headache.

June 15—A congress on medicine and insurance, co-sponsored by the Association of Life Insurance Medical Directors of America and the American Medical Association has been scheduled at the Fairmont Hotel, San Francisco, Calif. The program planned will be designed to create deeper understanding of relationships between life insurance medical directors, medical examiners, and attending physicians. Two symposiums are scheduled.

June 16-20—The American Medical Association Annual Convention, with the theme "Keeping Up," will be held at Brooks Hall, San Francisco. Not only does the medical profession have to keep up with demands for more service and more personnel, the physician faces the personal responsibility to keep up with medical developments. Approximately 600 scientific papers are to be presented and more than 250 scientific exhibits will be on display as well as many technical exhibits. Four General and 23 Scientific Sessions will offer programs.

June 26-28—Children's Hospital, Denver, Colo., will hold its Summer Clinics at Vail. Five distinguished faculty members will present morning sessions; afternoons are for leisure in this inspiring Rocky Mountains area. Fee: \$40.

NOTICE

The product referred to in the article "Pre-operative Medication with Rectal Pylamine-Pentobarbital," by Ross Schlich, M.D., and Edward Evenson, M.D., which appeared in the March, 1968, issue of the Illinois Medical Journal, is Emesert and is available from Arnar-Stone Laboratories, Inc., Mount Prospect, Ill.



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for May, 1968

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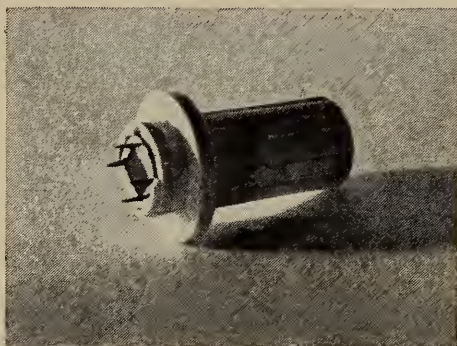
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



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OBITUARIES

***Dr. Walter H. Baer**, Peoria, died March 26 at the age of 65. He served as superintendent of Peoria State Hospital, was a past deputy director of mental health services in the Illinois Department of Public Welfare, and was a past president of the Illinois Psychiatric Society.

***Dr. Erwin Goodman**, Morton Grove, died March 17 at the age of 38.

***Dr. Clarence C. Holman**, 83, an Effingham physician who had practiced medicine for 48 years, died March 1. He was one of the founders of the original Effingham Clinic, a member of the Effingham Masonic Lodge for more than 50 years and had served on the Board of Education; a member of ISMS Fifty-Year Club.

***Dr. Erwin O. Krausz**, Chicago, died March 25 at the age of 80.

Dr. Bertram A. Marsden, Jerseyville, a practicing physician for 51 years, died Feb. 18 at the age of 76.

Dr. E. P. McLean, Brownsville, Tex., died Feb. 18 at the age of 77. He was a graduate of the University of Chicago, and of Rush Medical College. He had practiced medicine for 20 years in Decatur.

Dr. Donald F. Mirick, a former Clinton County medical examiner, died March 23 at the age of 49.

***Dr. W. E. Phillips**, Cisne, a practicing physician for 54 years, died March 24 at the age of 80. He was a member of ISMS Fifty-Year Club.

***Dr. Don C. Sutton**, Evanston, a physician and Northwestern University professor emeritus of medicine, died March 8 at the age of 81. He was a member of ISMS Fifty-Year Club.

Dr. Kathryn Haage Swartz, Forest Park, 106, died March 6. She was one of the first woman graduates of the University of Illinois Medical School.

***Dr. John R. Winston**, Chicago, 58, died Feb. 9. He was past medical director of the Atchison, Topeka and Santa Fe Railway System.

* *Member of Illinois State Medical Society*

Veterans on the VA pension rolls who are so seriously disabled that they need regular aid and attendance are eligible to receive \$100 a month in addition to their pension, according to the Veterans Administration.

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SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 12
SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 13
SPECIALTY REVIEW COURSE IN MEDICINE, Part II, June 3
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request
Dates

PROCTOSCOPY & VARICOSE VEINS, One Week, June 10
BLOOD VESSEL SURGERY, One Week, May 13
MANAGEMENT OF BURNS, Two Days, June 7
BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks, July 8
FIBEROPTIC CULDOSCOPY & PELVIC PERITONEOSCOPY, July
9
VAGINAL APPROACH TO PELVIC SURGERY, One Week, June
3

ADVANCES IN MEDICINE, One Week, May 13
ADVANCED HEMATOLOGY, One Week, June 10
CLINICAL ENDOCRINOLOGY, One Week, June 24
PULMONARY FUNCTION TESTS, Three Days, July 10
RADIOISOTOPES, One or Two Weeks, First Monday each
month
ANESTHESIA, Inhalation, Endotracheal, Regional, Request
Dates

*Information concerning numerous other
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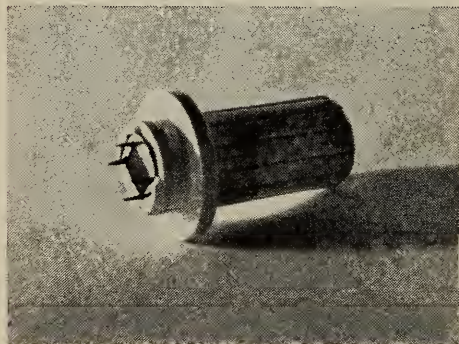
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Make tuberculin testing routine
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



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University of Chicago Family Planning Service

A family planning service at The University of Chicago has been established with the aid of a \$175,000 grant from The Rockefeller Foundation.

Operated by the University's Department of Obstetrics and Gynecology, the service will establish an interdisciplinary program coordinated with the University's Population Research and Training Center.

The research, training, service, and education program will concentrate both on broad aspects of population problems and specific problems such as contraception, education, limitation of family size, and spacing of children.

Dr. Joseph R. Swartwout, Associate Professor of Obstetrics and Gynecology, will direct the service. Working with him will be Dr. Frederick P. Zuspan, the Joseph Bolivar DeLee Professor and Chairman of the Department of Obstetrics and Gynecology. Dr. Zuspan is also Chief of Services of Chicago Lying-in Hospital.

The training program, explained Dr. Zuspan, will include instruction in family planning counseling for practicing physicians, University of Chicago Hospital residents and medical students, and paramedical personnel, especially nurses.

LSD Use Cut Down

(Continued from page 584)

In regard to drug-using communities, Dr. Levine pointed out that "communication among residents of the hip world and interestingly, to those of the square world is frequent and rapid, considerably aided by the many underground newspapers. Slogans like 'love' and 'flower power' and happenings like 'be-ins' and 'love-ins' are generated by the hip world and devoured by the square world with the mass media serving as the connection delivering the vicarious experience.

"I believe that the peak of illegal use and the peak of interest in the drug by the public has been reached, and over the next 30 years"—LSD was first synthesized 30 years ago—"I predict that LSD will return to the laboratory from which it so boldly bounded," he said.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

PUBLISHED MONTHLY BY: BLUE SHIELD PLAN OF ILLINOIS MEDICAL SERVICE • 425 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60690

Vol. 2, No. 6

June, 1968

Rising Health Care Costs

Dr. Milford O. Rouse, President of the American Medical Association, in a recent article said: "Efforts must be made by all segments of the health services industry, government, labor, and the public to moderate these costs which have risen because of inflation, increased demands for services and the enactment of government health programs which added hundreds of millions of dollars to the already over-heated competition for health services. The AMA has urged individual physicians to do everything possible to help their patients get the most out of their health care dollar."

In keeping with the AMA's request, Illinois Blue Shield and the profession are working together to see that individuals receive maximum benefits for their pre-payment dollar.

At times it is necessary for us to seek the advice of County Medical Society committees, District committees, and State Medical Society committees to assist in our joint efforts.

Administrative costs are also a factor in the total cost of health care. The physician and his office assistant play a key role in this special area. When information supplied by the physician or his assistant is incomplete, it is necessary for us to contact his office for additional information before payment can be made.

Details in connection with the description of the services provided or procedures performed help us speed payments. It is also important for us to know the subscriber's name, which appears on the Blue Shield identification card, the name of the patient, the certificate number and the patient's age for positive identification.

When the patient's correct age is not indicated, our electronic data processing equipment will reject a **Physician's Service Report**.

Omitted information adds to the time and effort required to process the claim, and to the cost of health care.

Should you or your office assistant want information pertaining to Blue Shield's **Physician's Service Report**, please contact our Professional Relations Department, Mrs. Loretta O'Donnell, 425 North Michigan Avenue, Chicago, Illinois 60611, telephone MO 4-7100, extension 580. For assistance in completing Medicare Form 1490, **Request for Payment**, contact Mrs. Suzanne Rudd, extension 256.

NABSP Serves All Plans

The National Association of Blue Shield Plans serves its members much the same way the AMA serves State Medical Societies.

The National Association, located in Chicago, assists in coordinating coverage, operations, and practices of its member plans.

Blue Shield Plans share many common problems in billing, accounting, claims processing, data gathering and marketing and are assisted by the National Association in solving problems that confront them.

NABSP conducts national and regional conferences to gain the experiences of expert advisors in helping to increase efficiency and reduce administrative costs.

It recognizes the autonomy of state and local Plans and offers many services to its Plan members including guidelines for product development, market research, public education, analysis of data.

An important function of NABSP is to establish and maintain high standards of organization and performance necessary for any association endorsed by the medical profession.

Blue Shield Plans Operate Locally

The Blue Shield Plan of Illinois Medical Service is one of 73 doing business in the United States.

Each Plan is an independent local medical service corporation organized for the purpose of pre-paying the costs of medical and surgical services provided by physicians in the community.

Plans must be specifically approved by their local or State Medical Society. Medical policies are established by the Plan's Board of Trustees and directed by physician personnel.

In response to local needs and demands, Plans differ in management and scope of covered benefits. By remaining local, Blue Shield Plans have the flexibility to respond to changing market conditions.

Blue Shield also participates in many national accounts which are administered at the local level, and provides uniform protection for employees of the steel industry, the motor industry, the federal government, and many other national groups.

Without losing local identity and autonomy, Blue Shield Plans have expanded and improved their services to the best interests of their members and the profession.

ASK BLUE SHIELD

● ● ● ABOUT MEDICARE

Q When a Medicare claim is paid to my patient, will I receive a copy of the Explanation of Benefits form?

A When payment is made to the patient, either on the basis of a paid or unpaid itemized bill, you will not get a copy of the Explanation of Benefits form.

Q Is treatment of a dislocated toe a covered service?

A Treatment of a dislocated toe by surgery is a covered service. However, if the dislocation is treated by non-surgical methods (taping or by other non-surgical reductions), the service is not covered.

Q If I accept assignment, is it necessary for the patient to sign the Request for Payment form?

A Some patients have challenged assigned payments stating that they did not make an assignment. Therefore it is necessary to have the patient's signature on all assigned claims unless a blanket Form 1490 has been submitted for the same illness.

Q When I accept assignment and treat my patient over an extended period of time for the same condition, do I need the patient's signature each time I bill the carrier?

A No you do not. You may have your patient execute a blanket assignment by signing a brief statement as follows: "I request that payment under the medical insurance program be made directly to Doctor _____ on any unpaid bills for services furnished me by the physician during the period _____ to _____." However, the period should extend no longer than the end of the calendar year in which the assignment is made except when it is in the last quarter of the year but then no later than the end of the following calendar year. When you submit Form 1490 for payment, indicate in the space provided for the patient's signature "This is a continuation of a course of treatment for which patient's assignment was previously obtained."

Q When a patient is unable to execute a Request for Payment himself, how is the request made?

A The request may be made on his behalf by his representative payee. The signature line of the Request for Payment, Form 1490 should be completed with the name of the patient followed by "By" and the representative's signature and address.

Medicare Guide Being Mailed

The Social Security Administration is mailing to all physicians copies of **Your Medicare Handbook**, prepared for Medicare beneficiaries, which includes 1967 amendments to the Medicare Law.

Although the handbook is prepared for Medicare

beneficiaries, it is being mailed to physicians and their office assistants to provide a source of answers to questions frequently asked by Medicare patients.

SSA is in the process of revising **Medicare—A Reference Guide for Physicians** which will be mailed to all physicians when completed.

Complete Information Needed

In many instances, Medicare payments are delayed because important items are omitted from the Medicare Form 1490, Request for Payment, or from the itemized statement submitted to the Part B carrier.

Omitted information delays payment either to the physician who accepts assignment or to the patient who is billed directly and makes it necessary for us to contact you before payment can be made.

When possible, we will telephone your office for the needed information. At times it will be necessary to write. When a letter is necessary, it will notify you that the claim will have to be settled on the basis of the information submitted, which might result in a disallowance or a reduction in the payment, unless the needed information is received within a month.

When only the physician can supply the information, and for some reason has not done so, it may be necessary to ask the local medical society to assist in obtaining it for us.

However, every effort will be made to obtain the information by phone or by letter and we appreciate your cooperation in carrying out this responsibility.

Our Government Contracts Division

reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during April for over 53,000 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding \$3,400,000. For the year 1968 through April, payments have been made on over 255,000 cases for about \$15,000,000.

The number of cases processed in April under Part A exceeded 61,000 with payments to providers amounting to more than \$20,000,000. For the year 1968 through April, over 275,000 cases have been processed and payments to providers have exceeded \$75,000,000.

NOTICE

To help speed payments, physicians in the counties of Cook, DuPage, Kane, Lake and Will may obtain a supply of SSA 1490 Request for Payment forms with their name imprinted on them by writing to Government Contracts Division, Blue Cross-Blue Shield, 300 North State Street, Chicago, Illinois 60690.

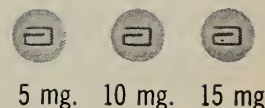
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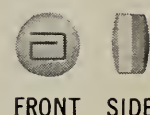
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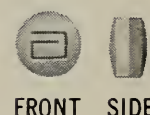


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Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10" x 10") booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



*Please see Brief Summary
on next page.*

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Brief Summary

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10 mg. Methamphetamine Hydrochloride,
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15 mg. Methamphetamine Hydrochloride,
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Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.



801444

Loyola University Stritch School of Medicine and New Medical Complex

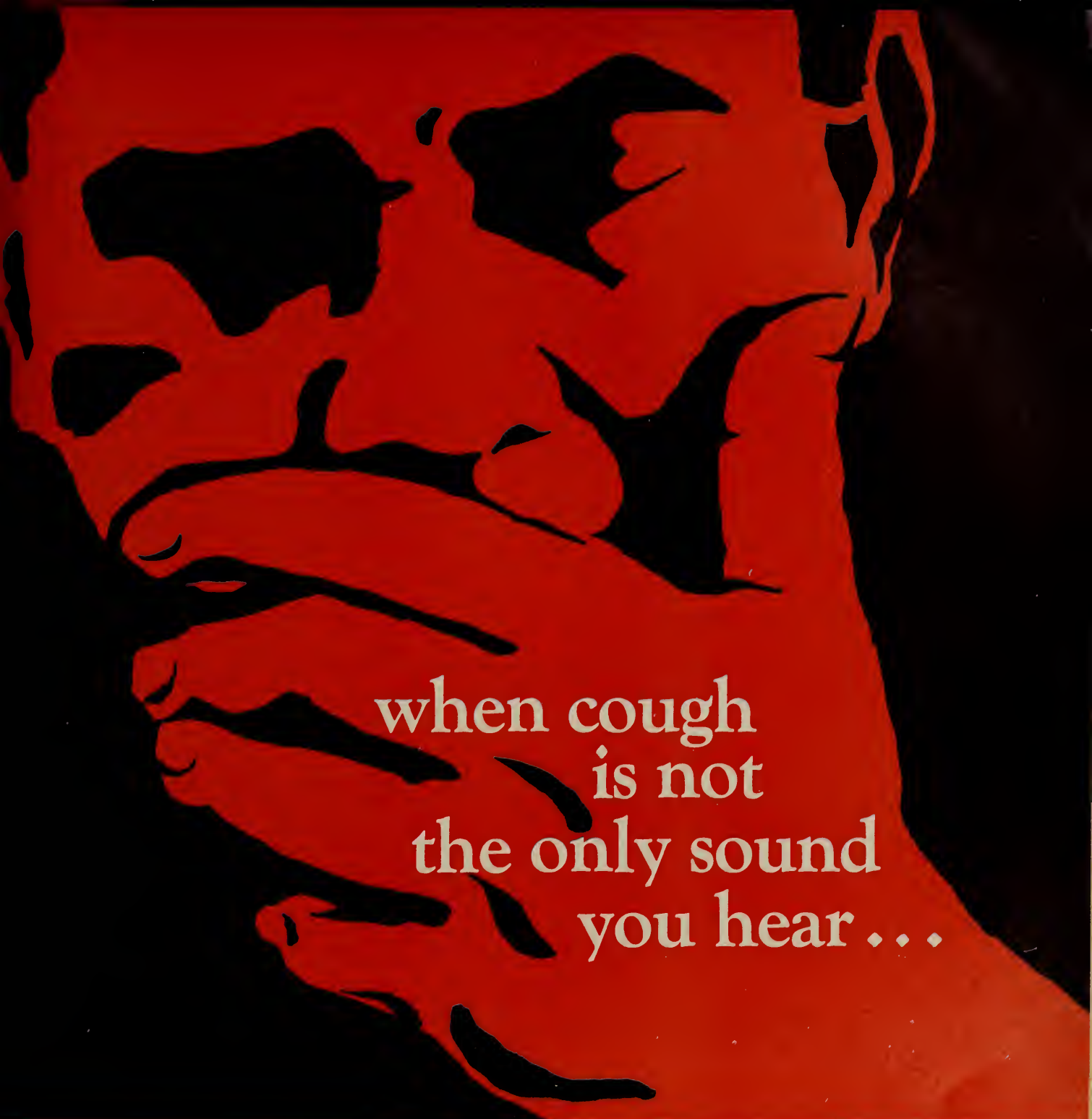
One of Illinois' decisive medical developments of recent months has been the complete relocation of the Loyola University Stritch School of Medicine from a crowded downtown Chicago location to a modern suburban setting in Hines. This permits a strong interaction between Stritch, the Hines Veterans Administration hospital, largest general medical and surgical hospital in the VA system, and the State of Illinois' newly dedicated John J. Madden Mental Health Center. In addition, the Medical School for the first time will have its own teaching hospital (151 beds) and ambulatory care center.

The medical school and hospital are two of three major components of the new Loyola University Medical Center which is scheduled for completion in 1968. The third is the School of Dentistry, the state's largest and oldest, which also will be moving from an urban locale.

Space and strategic geographic location, as well as the neighboring health facilities, were prime factors in the selection of Hines as the new home for the Medical Center. The center, situated within metropolitan Chicago's population center, is but five blocks from the Eisenhower Expressway and within five minutes of the East-West and North-South Tollways. It has 61 acres on which to carry out expanded activities.

In anticipation of the relocation, this year's freshman class of medical students was increased from 88 to 108. This boost, in time, will lift the total school enrollment to 432 compared with the present 352. The school also offers a graduate program which has grown from only two students in 1947 to the current 101, divided fairly equally among anatomy, biochemistry, microbiology, pharmacology and physiology. The faculty totals 600 of which 100 are full-time. Stritch, despite a growing westward dispersal of students for internship and residency, continues to be a major educator of doctors practicing in the Chicago area, where more than 21 per cent of the physicians are Loyola Graduates.

Now in its 53rd year, the Medical School assumes a role of service to Mid-America of a scope few could imagine only a decade ago. With valuable space on which to develop, the school undoubtedly faces additional heights of performance.



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The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

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Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

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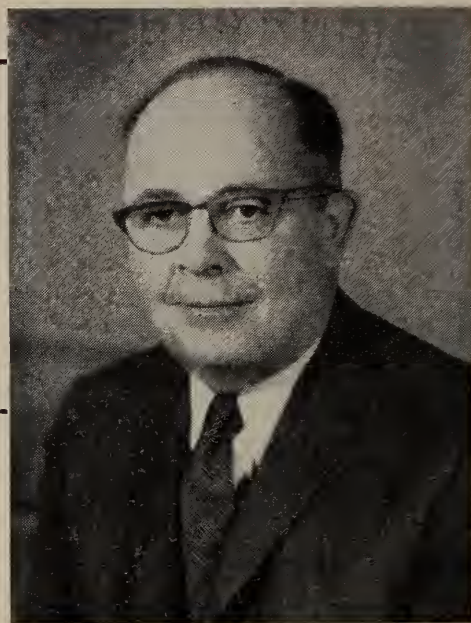
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The president's page



Philip G. Thomsen, M.D.

As I assume the role of president of our state society, many concerns enter my thoughts.

Our state sorely needs thousands more practicing physicians across her length and breadth; fifteen county seats have no doctors at all.

Medical schools are not producing enough physicians, and hospitals are turning more and more doctors into salaried employees.

Inflation has pushed costs up, and our critics bracket our modest fee increases with rising hospital charges.

Many doctors are confused or unhappy about Medicare and public-aid fees and the agencies that handle them.

Government is making us the whipping-boy for its own frustrations in the welfare field, and threatens even greater inroads on our careers.

We face not challenges, but a swarm of emergencies! Together we must put forward not only the words but the deeds that befit emergencies. The facts are on our side, and we must tell them. The responsibilities for meeting medical problems are ours, as physicians, and we must fill them. If we do not tell our side of the story, Government planners and theorists and sociologists will be increasingly more effective with their demagoguery and their doctored statistics . . . if you'll pardon the expression.

To relieve the physician shortage, there are several steps we must take. We must insist that medical schools concentrate on teaching, instead of basing their prestige, and their faculty assignments, on research. We must see that teaching, not just research, is recognized in Federal grants to

these institutions. We must attend budget hearings in our General Assembly, and see that any per-student subsidies to Illinois' medical schools be tied to teaching.

We particularly need to get more family doctors into our communities. Knowing that pre-med students with "A" grade averages tend to favor research or teaching careers, we must urge medical schools to review their entrance standards . . . be more considerate of those "B" and "C" students who yearn to go into practice. For these are likely to be the very ones who will try extra hard, put down roots in a community, and be devoted family doctors.

On the question of doctor bills, we know that expenses are taking an ever greater portion of our gross income . . . that most of us raise our fees only to offset several years of accumulated inflation . . . that the doctor's share of the health-care dollar has been steadily shrinking, from almost 28 cents in 1960 to an estimated 22 cents today.

Amid the inflationary spiral, we must try to protect the budget of the patient. We want to make his hospital stay as short as good judgment allows . . . trim routine tests to the really essential . . . prescribe drugs by their generic names.

As for fees under the Medicare Law, we must realize that—like it or not—we are part of it. While the Medical Society will fight for the physician's right to the usual,
(Continued on page 692)

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PRESIDENT'S PAGE

(Continued from page 688)

customary and reasonable fee, he must seek no more than the fee. If the fees are not handled equitably, disputes will fester and grow until the Government completely usurps the field of medicine.

We must be strong, too, in resisting the encroachments of corporate practice of medicine . . . the zealous moves by hospitals to convert more physicians into salaried employees. We tried to meet this problem with a legislative bill—and now are striving to negotiate it with the Illinois Hospital Association. One way or the other, we must and will preserve the individual dignity of the physician . . . the personality of the doctor-patient relationship.

In all of our efforts, the bedrock of our success is public confidence and support. We must tell the public the facts without hesitation or double-talk. We must tell the people how the physician shortage hurts **us** as well as **them**. We must tell the people how governmentalized, depersonalized medicine hurts **them** as well as **us**.

We must carry our cause from the state and district to the county and local levels, because that cause must be nourished at the grassroots. To get to the grassroots, the Society this past year inaugurated the President's Tour. Dr. DuPuy and I went to a dozen cities up and down the state . . . addressed county medical societies . . . gave interviews to newspapers . . . appeared on many radio and television programs. On these visits, we stressed the need for joint action among physicians.

During the coming year, your Medical Society intends to expand the President's Tour program. I want to be available to you **anywhere, at any time** . . . because I want to hear **your** ideas about what ISMS can do for you.

I truly face more than a challenge—and so do you. For medicine itself is a patient today—medicine itself is on an emergency list. Its professional health, its breath of freedom, its future are in danger. This is a case that demands the judgment, the initiative, the vigor of us all. For this case we all must be "the doctor in the house." Together, let us answer medicine's cry for help!

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New ISMS President, President-Elect, Board Chairman, and Executive Administrator



Edward W. Cannady, M.D.



Frank J. Jirka, Jr., M.D.

Thomsen has served as chairman of the ISMS Finance Committee and has been a member of the Committee on Legislation, Medical Education and Liaison with Medical School Deans. He has also been chairman of the Advisory Committee to the Il-

PHILLIP G. THOMSEN, M.D.

Dr. Thomsen, a general practitioner from South Holland, became president of the Illinois State Medical Society at the concluding session of the society's 128th annual meeting in Chicago, May 22, 1968. Dr. Thomsen had been a member of the ISMS Board of Trustees from 1963 to 1967. A specialist in general surgery, Dr. Thomsen is a 1934 graduate of the University of Illinois College of Medicine.

After interning at Ravenswood Hospital in Chicago, he established a practice in Dolton in 1935. In 1947—after serving with the Air Force in World War II—he founded the Thomsen Clinic, which today has a staff of seven physicians. Dr. Thomsen served three terms as chief of staff of St. Francis Hospital in Blue Island and is chairman of that hospital's surgical staff.

A past president of the Southern Cook County Branch of the Chicago Medical Society, Dr.



Philip G. Thomsen, M.D.



Roger N. White

linois Medical Assistants Association.

EDWARD W. CANNADY, M.D.

Dr. Cannady, an internal medicine practitioner in East St. Louis, was named president-elect of the Society. He was speaker

of the ISMS House of Delegates from 1964 to 1967 and will assume the presidency in May, 1969.

A physician since 1931, Dr. Cannady has been active in medical affairs on the local, regional and national as well as state level. Many of these activities have related to home care, aging, and cardiovascular disease.

He is governor of the American College of Physicians for downstate Illinois, and is a member of both the Illinois and Bi-State (St. Louis Metropolitan area) Committees for the Heart Disease, Cancer and Stroke Regional Medical Programs.

A member of the American Medical Association's House of Delegates since 1961, he formerly was chairman of its Illinois delegation and is on the AMA's Committee on Aging. In 1961 he was a delegate to the White House Conference on Aging. He is a past president of the Illinois Joint Council on Aging and the Illinois Heart Association. Currently he is a member of the Illinois State Council on Aging, by appointment of former Gov. Otto Kerner.

A graduate of Washington University Medical School, St. Louis, he is a member of the board of directors of Metropolitan (St. Louis) Hospital Planning Commission. Dr. Cannady makes his home in Belleville, Ill. In 1952 he was president of the St. Clair County Medical Society, and also is a past president of the Home Care Association of St. Clair County.

FRANK J. JIRKA, M.D.

Dr. Frank Jirka, Jr., a urologist residing in River Forest was elected chairman of the Board of Trustees of the Illinois State Medical Society.

Active in many medical activities, Dr. Jirka is president of the Suburban Cook County Tuberculosis Sanitarium District Board, vice-president of the staff at MacNeal Memorial Hospital, Berwyn, and immediate past president of the Douglas Park Branch, Chicago Medical Society. He is also on the staff of St. Anthony de Padua Hospital, and technical consultant to the Illinois Commission on Children.

Dr. Jirka was born July 23, 1922. His maternal grandfather was the late Mayor Anton Cermak of Chicago. His other grandfather was a physician, and his father was a surgeon here.

He received his early education at St. John's Military Academy, Delafield, Wis., and Knox College, Galesburg. A Navy frogman in World War II, he lost both legs when a small ship was blown up beneath him at Iwo Jima.

Dr. Jirka is a diplomate of the American Board of Urology and a fellow of the American College of Surgeons, the International College of Surgeons, and the Institute of Medicine of Chicago.

ROGER N. WHITE

Roger White, a veteran of 17 years service in medical and hospital administration, was named executive administrator of the Illinois State Medical Society. Announcement of White's appointment was made Tuesday (May 21) before the House of Delegates at the annual meeting.

White—who has been assistant executive administrator and director of the ISMS legislative and public affairs division since 1960, assumes his new office July 1. He succeeds Dr. George F. Lull, former assistant U.S. Surgeon General and executive vice president for the American Medical Association.

A native of Dalton, Pa., Mr. White is a graduate of Pennsylvania State University and served as a navy lieutenant for three years with the Naval Air Transport service during World War II.

After the war, he worked for 4 years in educational sales promotion for the International Correspondence Schools in Scranton, Pa. In 1951 he joined the staff of the Pennsylvania Medical Society in Harrisburg, Pa. and in 1954 became executive director of the Hospital Council of Lackawana County, Pa.

He is a member of the American Association of Medical Executives, Illinois Hospital Association, American and Public Health associations, and Pi Kappa Alpha fraternity.

Acute Renal Failure In Pregnancy

By JOHN J. GARRETT, M.D./ST. LOUIS, MO.

A sudden and troubling drop in urine flow followed by the development of progressive renal insufficiency and clinical uremia is a misfortune which may accompany a variety of obstetrical accidents. The association between pregnancy and acute renal failure is a frequent experience in centers specifically organized to care for patients with oliguria or anuria. Some 20 percent of all cases of acute renal failure occur in the pregnant or recently delivered female.

The clinical background and obstetrical setting in which the oliguric or anuric state develops are, as outlined in Fig. 1, most varied. Despite the fact that the clinical events are diverse and seemingly unrelated, certain common denominators emerge which aid classification, and more importantly, provide insight into the pathophysiology of acute renal failure. An oversimplified but clinically useful concept would explain all of the acute renal problems associated with pregnancy as arising from either renal ischemia, exposure to nephrotoxins, or toxemia.

In the majority of cases of acute renal failure, the underlying pathologic lesion is tubular necrosis (Fig. 2). The sequence of events involved in the pathogenesis of this lesion appears to be hemorrhage, decreased circulating volume, renal ischemia, and tubular damage. In some situations, the same phenomena lead to infarction of the glomerular zones of both kidneys or bilateral cortical necrosis (Fig. 3). This is a rare disorder which appears to have some correlation with premature separation of the placenta. Although frequently regarded as a "typical" renal lesion associated with pregnancy, it is important to recall that it occurs at all ages and in both sexes. In our view, acute tubular necrosis and bi-

lateral cortical necrosis are clinically indistinguishable, produce identical syndromes, and are differentiated only by biopsy.

Fig. 1.

ACUTE RENAL FAILURE IN PREGNANCY Clinical Background

Shock

Abruptio Placenta, Post-Partum Hemorrhage

Nephrotoxin

Hemoglobin, Mercury, Carbon Tetrachloride

Toxemia

? Circulating Vasoconstrictors
Disseminated Capillary Thrombosis

The presence of an endogenous or ingested nephrotoxin capable of producing acute tubular necrosis is another potential etiologic factor in the urinary suppression which may accompany pregnancy. The role of toxemia as a predisposing factor in renal failure is less clearly defined, but there is little question that in some obscure way it helps set the stage for either tubular destruction or cortical infarction.

Clinical Picture

With this brief review of the pathology and pathogenesis of acute renal failure as a background, it is perhaps most appropriate to move on to a discussion of the clinical characteristics of this syndrome. There are two outstanding features. The first of these, and in most cases the initial or alerting abnormality, is oliguria, a drop in urine flow which does not respond to volume replacement or intravenous fluid therapy. In the first twenty-four hours which follow a catastrophe of the type outlined above, the problem of differentiating acute renal failure from dehydration or hypovolemia may be a difficult one. Fig. 4 provides some guidelines for the differential diagnosis of oliguria. This approach is



John J. Garrett, M.D., is Associate Professor of Medicine, St. Louis University School of Medicine and Director of the Hemodialysis Unit at John Cochran Veterans Administration Hospital, St. Louis, Mo. He received his M.D. from Harvard and served residencies at the Albany Medical Center Hospital, New York, where he was also a Research Fellow in Metabolic Diseases.

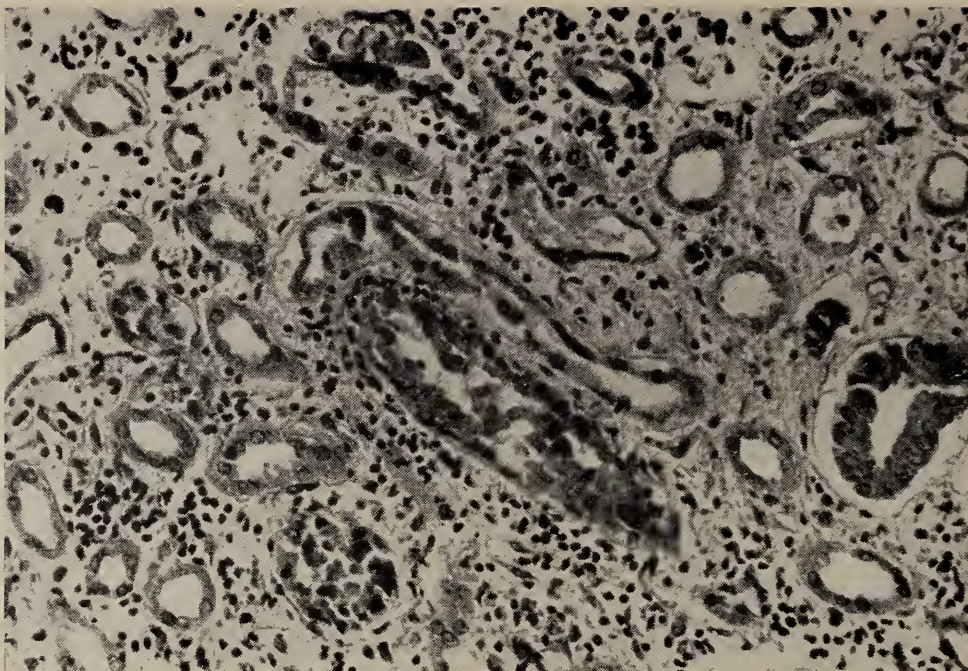
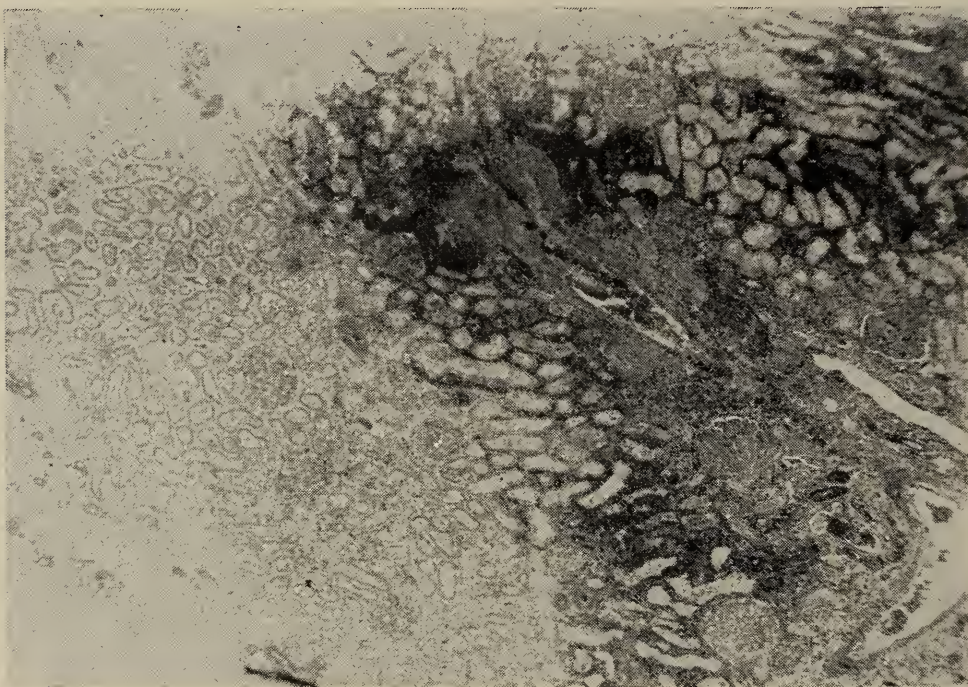


Fig. 2. Acute Tubular Necrosis (10 Days after Shutdown) The section shown is from the medullary portion of the kidney. Interstitial edema and inflammatory reaction are apparent. The tubular epithelium shows a variety of changes ranging from complete destruction with intraluminal cast formation to brisk regeneration.

Fig. 3. Bilateral Cortical Necrosis (Autopsy Specimen) The dark zone represents a cortical area of hemorrhagic infarction and the light area a zone of coagulation necrosis. There was diffuse involvement of both kidneys and prolonged anuria with these lesions.



based on an appreciation of renal homeostatic mechanisms in the patient whose problem is volume depletion. Physiologic responses in this situation are totally oriented toward the reabsorption and conservation of filtered sodium and water and the maximum concentration of urea and

other solutes in as small a volume as possible. The urine of the hypovolemic patient is scanty, highly concentrated, contains little sodium, and has a high urea concentration when compared to plasma. Conversely, the "kidney" of acute renal failure, with patchy areas of necrosis and

edema, is no longer a functioning organ. The small amount of "urine" which it excretes has a strong resemblance to unmodified glomerular filtrate, and the various solute concentrations approach those of plasma.

Fig. 4.
DIFFERENTIAL DIAGNOSIS OF OLIGURIA

Dehydration or Hypovolemia	vs	Acute Renal Failure
200-400 ml	Urine Volume	0-400 ml
1.030	Specific Gravity	1.010
0-10 mEq/24°	UNa	50 mEq/24°
100	Urea	10
	U/P Ratio	

The problem of oliguria due to hypovolemia is often resolved by a therapeutic trial of volume expanders. In our experience, whole blood and saline are the most effective intravenous solutions. The unique properties often attributed to specialized infusions are often related to their role as volume expanders, particularly when this results in improved renal perfusion and increased urine flow.

It is an unusual individual, especially in the age group under discussion, who cannot tolerate a two liter trial infusion over a period of two to four hours. The major exception to this statement is, of course, the

edematous-toxemic whose body water and cardiac status may already be compromised. If oliguria persists after what seems to be adequate fluid replacement and the correction of hypovolemia and hypotension, and if analysis of the available urine shows it to stimulate plasma rather than useful urine, then a working diagnosis of acute tubular necrosis is justified.

The second distinguishing and diagnostically useful characteristic of acute renal failure is the rapid rate of progression of both the clinical and biochemical abnormalities of uremia. It is a clinically useful rule of thumb that the urea levels rise in increments of 25 mg percent during each day of acute renal failure. If, for example, on the fourth day of oliguria the urea level is 54 mg percent, the problem is almost certainly pre-renal, i. e., related to cardiac failure, a continuing deficit in circulating blood volume, salt depletion, or persistent vascular collapse. In cases of true acute renal failure the urea level is almost always in the range of 100 mg percent by the fourth day.

A case seen recently at our center provides a classic demonstration of the clinical

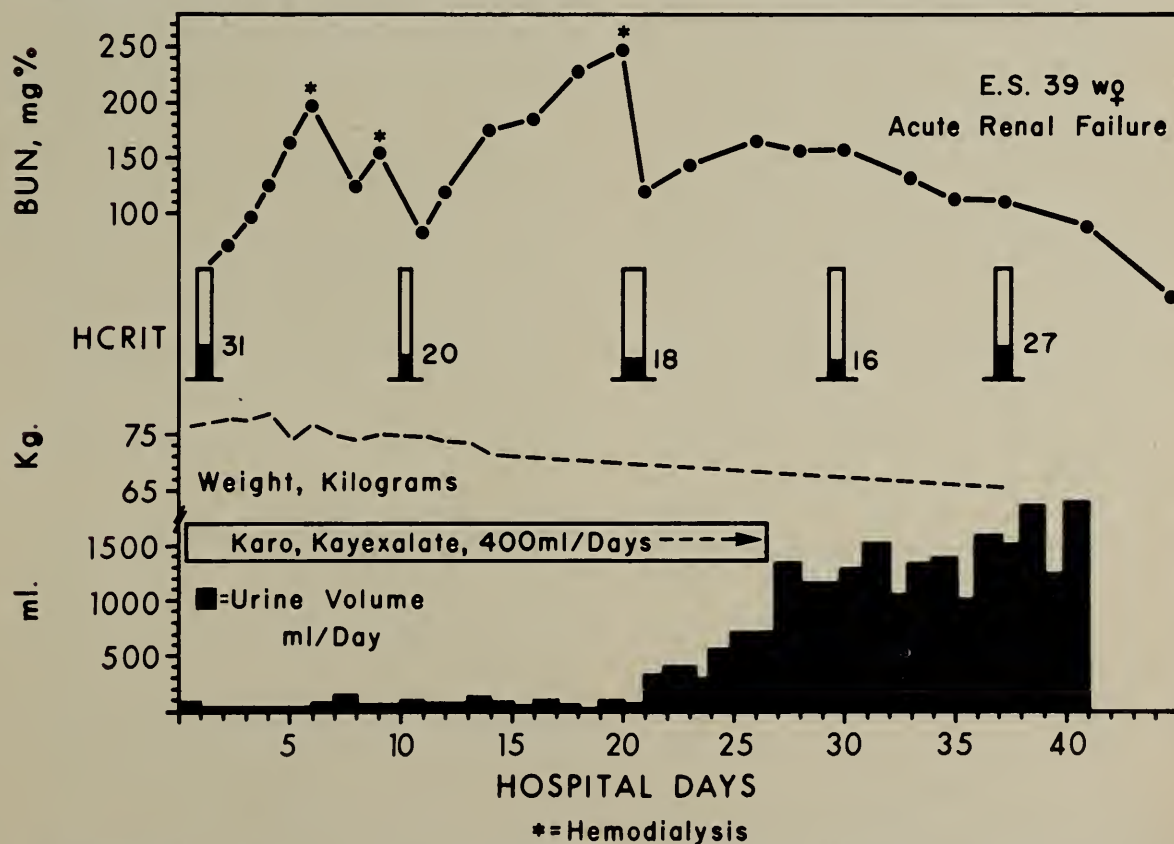


Fig. 5. The course of acute renal failure following premature separation of the placenta and hemorrhagic shock. The rapid progression of uremia, severe oliguria, and the development of anemia are all characteristic findings in acute renal failure.

cal setting and clinical characteristics of acute renal failure in pregnancy and will serve as an appropriate transition from a discussion of pathogenesis and recognition to a careful scrutiny of the principles involved.

E. S., a 39-year-old white married housewife, was transferred to the renal section at the St. Louis University Hospitals from a nearby community hospital because of anuria. Twenty-four hours previously, in the eighth month of an uncomplicated pregnancy, there had been sudden massive vaginal bleeding. She was taken to the emergency room of a nearby hospital and was appropriately treated with blood and saline. Bleeding and hypotension persisted, a diagnosis of abruptio placenta was made, and a hysterotomy was performed. The fetus was not viable. A total of eight units of whole blood was required to achieve stabilization of blood pressure and hematocrit. There was suggestive evidence of a mild reaction to one of the transfused units. A fibrinogen level was reported as "low normal" and fibrinogen was given.

Oliguria was apparent from the beginning, and at the end of the first 24 hours, the total urine volume was less than 100 ml. Lab data at the end of the first day showed a BUN of 52 mg percent, hematocrit 31, potassium 5.8 mEq/L, and total serum bilirubin 3.2 mg percent. The patient was transferred to St. Louis University Hospital. The clinical course is shown in Fig. 5. Severe oliguria persisted for 21 days. The patient became progressively uremic and required three hemodialyses. A spontaneous diuresis developed on the twenty-second day, and after that the course was characterized by steady improvement. She was discharged ambulatory on the forty-seventh hospital day. When evaluated one year later, the patient was symptom free and showed neither clinical nor laboratory evidence of kidney disease.

Management

Cases of this type obviously tax the physician's determination and judgment and provoke a series of physiologic and thera-

peutic considerations. It is worthwhile and encouraging to recall that when acute tubular necrosis is the underlying lesion, the chances for recovery are in the patient's favor. Statistical analysis of these cases has shown a 66-75 percent survival rate. The key to this is, of course, the inherent and dramatic ability of the tubules to regenerate and recover. This biologic potential of renal tubular epithelium is neither directed nor controlled by the physician, but by taking advantage of it his role becomes a supportive one directed primarily at the maintenance of life during the oliguric or anuric phase. The outstanding considerations which arise during this supportive operation are shown in Fig. 6.

Fig. 6

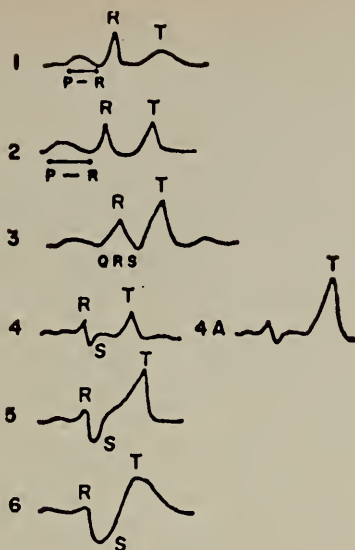
ACUTE RENAL FAILURE THE CLINICAL PROBLEMS

POTASSIUM
WATER
NITROGEN
INFECTION
DRUGS

Potassium

The risk of potassium intoxication is a unique and often lethal factor in cases of acute renal failure. The biological effect of an increase in extracellular fluid potassium concentration is manifest primarily on the myocardium, and the evolution of dangerous cardiotoxicity can fortunately be monitored with the electrocardiogram. The sequential nature of these changes is shown in Fig. 7.

Once the diagnosis of acute renal failure is established, several maneuvers should be initiated which will prevent hyperkalemia. It is unwise to await the development of potassium intoxication; it will usually occur. Overt, clinically obvious potassium toxicity is a major medical emergency, the treatment of which is difficult and frequently unsuccessful. It is far better to predict trouble with potassium early in the course of acute renal failure and to institute appropriate preventive measures then. The first of these is the absolute exclusion of potassium both from the diet and from parenteral fluids. It is our practice to obtain an electrocardiogram every twelve hours during the anuric/oliguric period. Hyperkalemia *per se* is not always a reliable index of the biologic effects of potassium; the real question is related to cardiotoxicity rather than to plasma levels



EKG IN POTASSIUM INTOXICATION

Fig. 7. Sequential changes are shown beginning with peaking of the T wave, lengthening of the P-R interval and a decrease in amplitude of the P wave. The T wave becomes higher and more pointed (2), the P wave changes become more pronounced and the QRS interval increases (3). A symmetrical or "tent-shaped" T wave (4) may have the same significance as a taller but asymmetric T wave (4A). The QRS interval increases, the S-T segment becomes nearly a continuous part of the ascending limb of the high pointed T wave (5), and these changes progress (6) to the so-called sine wave which precedes cardiac arrest. This figure has been reproduced from *Diseases of the Kidney*, Strauss, Maurice B., M.D. and Welt, Louis G., M.D. Little Brown and Company, Boston, 1963, p. 459.

alone.

If a trend toward potassium intoxication develops, potassium exchange resins should be used at definite intervals until this is either reversed or controlled. These can be given orally, through a gastrointestinal tube, or as a retention enema. Full-blown potassium toxicity with advanced and obvious EKG findings should not be temporized with and is an indication for immediate dialysis.

Water

The oliguric or anuric patient has lost the major homeostatic mechanisms for control of body water and is seriously threatened by overhydration. The simple formula for daily fluid volume requirement is well known to most physicians and is a well-established portion of the program for managing acute renal failure.

Daily Fluid Requirement = 400 cc + Losses

Losses obviously include renal and extra-renal sites of fluid and electrolyte de-

pletion. The oliguric patient with a measured upper GI loss of 800 cc due to vomiting or intubation might require the following:

$$\begin{aligned} &400 \text{ cc (Insensible Loss)} + 150 \text{ cc} \\ &(\text{Urine}) + 800 \text{ cc (GI Loss)} = \\ &1350 \text{ cc Total} \end{aligned}$$

The electrolyte composition of the fluid should be tailored to fit the losses. For the problem outlined above, it would be reasonable to prescribe 600 cc of glucose in water and 800 cc of glucose in saline. An invaluable aid in the control of fluid therapy is the record of daily weights on a reliable scale. Since 60-70 percent of body weight is water, the careful and precise monitoring of body weight offers daily insight into the accuracy of fluid management in these patients. It is desirable for the oliguric individual to lose one-half pound of weight per day. A gain in weight implies overhydration with the risks of water intoxication and pulmonary edema.

Nitrogen

Since the uremic syndrome is in part due to the accumulation of nitrogenous wastes, it is therapeutically sound to attempt to limit endogenous nitrogen breakdown by providing "nitrogen sparing" calories and by restricting exogenous or dietary protein. A number of imaginative and theoretically sound approaches such as butter, sugar, candy, intravenous and oral fat solutions, hypertonic solutions of glucose and ethanol have been tried and have their advocates. Any program which provides a thousand calories a day and which fits the individual patient requirement without accentuating inherent uremic gastrointestinal complaints or compromising venous infusion sites is acceptable. A simple solution of corn syrup and water or ginger ale made up to the appropriate volume will provide approximately 300 calories for each 100 ml.

Infection

Common causes of death during the course of acute renal failure are either septicemia or pneumonia. Staphylococci and gram-negative organisms are equally involved. The origin of the sepsis is not difficult to visualize. In some instances, as in septic abortion, it is present from the beginning. In other cases, it seems to represent the multiple portals of entry which

arise during the course of the disease. Fig. 8 provides a graphic and dramatic illustration of the problems encountered during the management of the case outlined above. The arrows indicate the sites of venous or arterial access necessitated by the protracted course and the need for hemodialysis. During this time, three organisms and a fungus were recovered from various infected loci. Another factor involved in the mortality related to infection is the "immune poverty" which accompanies the uremic state. Perhaps in part related to nutritional depletion and perhaps due to the general biochemical distortion of uremia, this susceptibility to infection is a universal experience and often defies chemotherapy.

Drugs

Any medication which is significantly dependent upon renal mechanisms for excretion or metabolism will accumulate in the blood of patients with acute renal failure, often to toxic levels. Two impressive examples of this problem are digitalis and kanamycin. About one-fourth to one-third of the usual dose of digitalis is required

for maintenance digitalization of these patients. The persistence of therapeutic levels of kanamycin has been noted for several days following a single parenteral dose of this antibiotic. Approximately one-fourth of the usual dose of kanamycin or colistin should be administered to patients with acute renal failure to avoid toxic accumulation of these drugs.

The Role of Dialysis

This discussion has emphasized the conservative treatment of acute renal failure. In some cases, particularly when the oliguric or anuric phase is of four to five days' duration and is well tolerated, this approach is adequate. If, however, uremic symptomatology develops, if potassium levels are not controlled, or if anuria is protracted, dialysis may be life saving. The mode of dialysis is not important. A technically effective peritoneal dialysis is as useful as hemodialysis. A more important consideration is early recognition of the problem, the earliest possible institution of the measures outlined above, and the

(Continued on page 762)

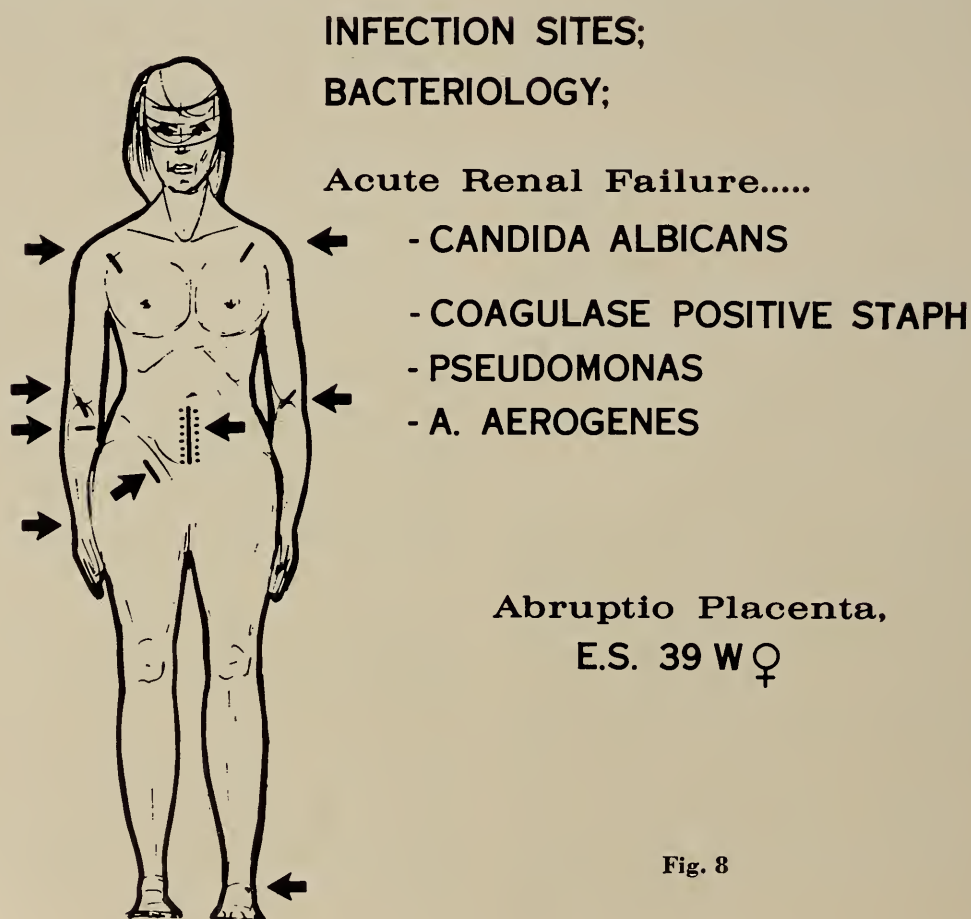


Fig. 8

The Temporo Mandibular Syndrome

By G. CLEVELAND OTRICH, M.D./BELLEVILLE

My interest in the temporomandibular syndrome stems from an experience I had with Dr. James Costen of St. Louis: An elderly patient came in complaining of terrific pain in the region of the occiput. While Dr. Costen was examining him, the patient said: "It might help you to know that the only way I can get some rest at night is to fold a towel, twist it, and put it in the corner of my mouth and bite down on it, then I am relieved of the pain!"

Dr. Costen ran down the nerve relationships of the temporomandibular joint and, later, wrote extensively and gave many lectures on the subject. I pursued the subject and found, for instance, that when a patient complains of itching ears which show no irritation, except from scratching, always check the temporomandibular joint.

An overbite is not difficult to diagnose, even at a distance, or on television. To illustrate, when I was giving a talk in Chicago, I selected Dr. Henry Mundt out of the audience and asked him to come to the platform. I placed my fingers in his ears and had him open and close his mouth. He was tender in the joint.

Measurement Technique

This is the measurement technique: (Fig. 1 and Fig. 2) Take the calipers that every dentist and ear, nose and throat specialist uses and measure from the corner of the eye to the corner of the mouth. Then measure from under the nose to under the chin—which should be the same. Dr. Mundt's overbite was about 10 millimeters.

Another test is to put the palm of the

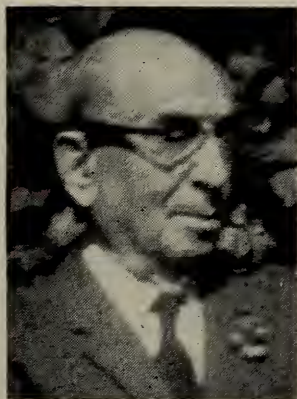


Fig. 1



Fig. 2

hand under the jaw or chin and have the patient open his mouth; this will produce



G. Cleveland Otrich, M.D., is an Otolaryngologist in Belleville. He received his M.D. from the University of Illinois College of Medicine and interned at Chicago Hospital and at Washington Park Hospital. Postgraduate study in Otolaryngology was taken at the University of Vienna as well as at Berlin and London.

irritation or tenderness if the joint is involved. It demonstrates irritation from an overbite on the cartilages lining the joint, which in turn, irritates the anterior auricular nerve. This explains the joint irritation.

Then, check the mouth. In a great number of cases, dentures are ill fitting and there is an overbite or there are missing teeth and the occlusion is bad. The pain that occurs along with the itching usually comes down around the ear to the occipital region.

Suggestion for Ophthalmologists

I also have a suggestion for the ophthalmologists. When patients come in with pain in or about the eyes, and there is suspicion of increased intraocular pressure, but it is not found, give them a temporo-mandibular test. More than likely, they will have tenderness and flinch. This takes place because the communicating branches of the anterior auricular nerve have communicating branches with the other nerves.

Another symptom has been mistakenly diagnosed as Migraine when it was a temporo mandibular syndrome, or a pressure of the middle turbinate on the middle branch of the sphenolatine branch on the uncinate process which has a communicating branch with the anterior auricular.

Another symptom to bear in mind is Globus-Hystericus, an older symptom in this specialty. This has caused much concern for even after thorough examination and scoping tumors may not be located. It has been found in this work on temporo mandibular that there is a communicating branch from the anterior auricular to the pneumogastric, and there may be a disturbance that gives the sensation of the stricture or tumor. Correcting the temporo mandibular irritation normally clears up the symptoms.

It is also recommended that patients with asthma or emphysema have an examination of the temporo mandibular. While this may seem unnecessary evidence exists to warrant it. In addition one might list the branches off the pneumogastric or vagus. Things to watch for would be spasms of the esophagus in any area.

Many years ago my colon was resected and I developed hiccups for 10 days postoperatively. The surgeon came in and said: "Doc, I think we are going to have to crush your vagus nerve."

I said: "Now just a minute!" I was shaken up, but remembered that my dentures had been loose and my jaws were shrinking to such an extent that I had to have them rebased about every two years. "You go down to the drug room and get me a couple of corks." He did, and I cut disks and put them back in my molar region. The next day, my hiccups subsided.

Well, they thought it was something else, but finally let me go home. I stuck to my disks for a few days and finally got tired, as we all do, and left them out. The next morning at 3 A.M., I woke up with a recurrence of my hiccups. I put the disks back in and kept them there until I could get to my dentist. After my dentures were corrected, the hiccups disappeared.

Dizziness and Dental Disturbances

The differential diagnosis also includes vertigo, including dizziness due to Meniere's syndrome. In many instances, the dizziness disappears after the correction of dental disturbances.

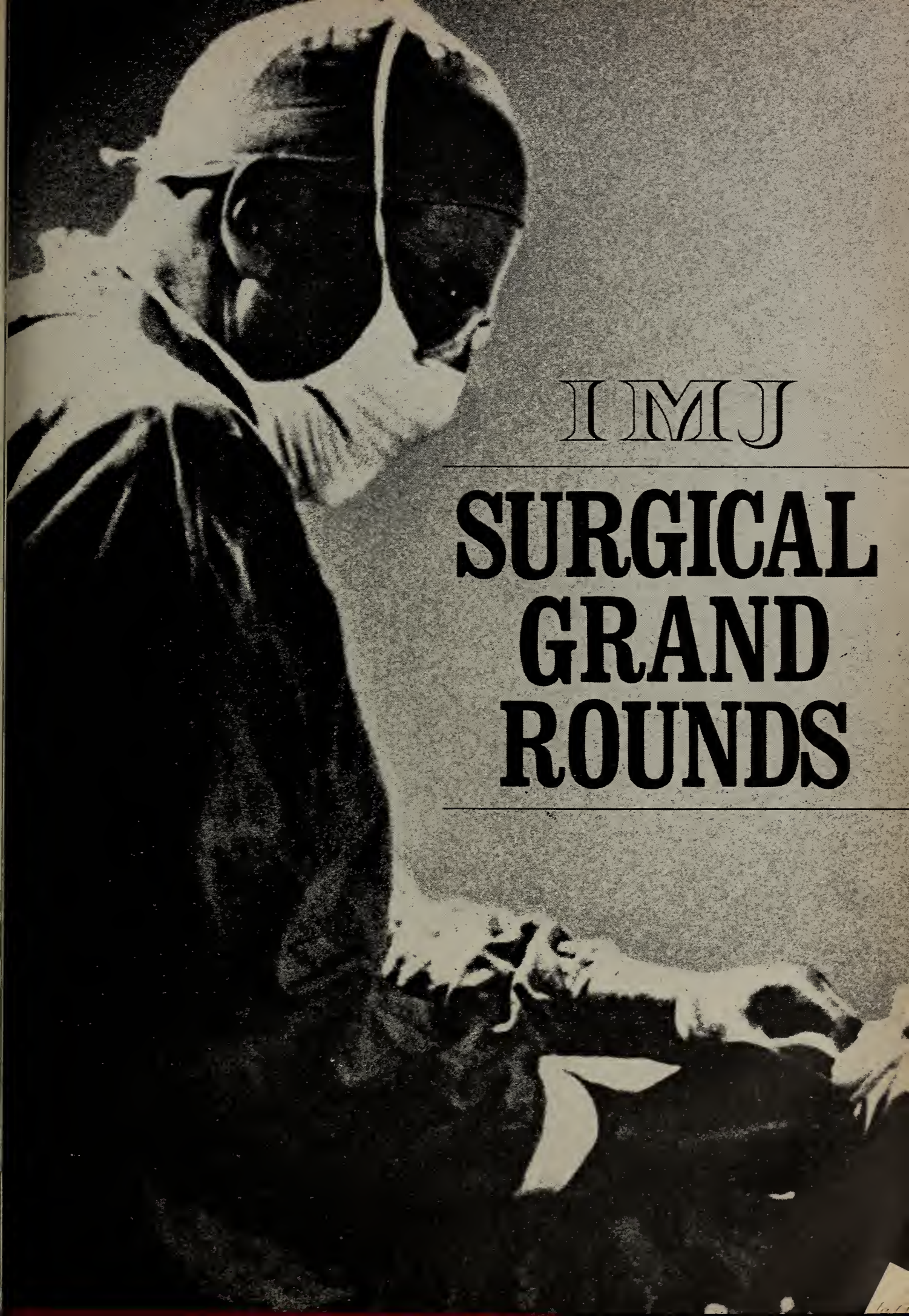
Patients with a burning tongue often think they have lumps in their tongue. Being cancer conscious they are scared to death. After examination of a routine nature there is often little determined. After a temporo mandibular check, 99% will show various bad occlusions that cause a temporo mandibular irritation. This has a direct communication with the sub-lingual nerve or glosso-pharyngeal.

Another patient was 14 years old. This girl had severe pain around her ear. She thought she had earache. There was a little overbite from an underdeveloped inferior maxillary. She flinched the minute I touched her temporomandibular joint. This girl had a perfect set of teeth, but she was a gum chewer.

When I told her to stop chewing gum, she thought I was some sort of crank. She couldn't figure out what gum chewing had to do with her pain. Again, I told her to stop the habit and come back in a week for another check-up.

After several days the pain had subsided. That night she decided to chew gum again with a return of her symptoms. She was finally convinced. The next morning she came in and said: "No more gum chewing for me." Gum chewing will produce much irritation.

(Continued on page 764)



U M J

SURGICAL GRAND ROUNDS

Endometriosis Of The Bladder

Surgical Grand Rounds are held weekly on Saturday at 8:00 A.M.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on September 9, 1967.

CASE PRESENTATION:

DR. JAMES DOWNING: Our patient, a 48 year old white female, was admitted to Passavant Memorial Hospital with frequency, dysuria and terminal gross hematuria. The patient was first seen in 1963 with frequency and dysuria but without hematuria at that time. Total hysterectomy with bilateral oophorectomy for endometriosis had been performed nine years earlier. Investigation four years ago was negative except for a urethral structure. Urine culture yielded *E.coli*. Dr. Lloyd treated the patient during the last four years with periodic urethral dilations and appropriate antibiotics which have controlled her symptoms. At present she has been receiving thyroid extract and Premarin. Physical examination: She was a healthy-appearing middle-aged female. There was a well healed midline suprapubic scar. Laboratory studies: blood count and urinalysis were normal. A urine culture was negative. An intravenous pyelogram was normal. Cystoscopy was performed and two 3 mm. diameter bluish cysts were seen in the fundus of the bladder. There were also four 1 mm. yellow nodules in the same area. Clinically a diagnosis of endometriosis was made. The lesions were removed with the resectoscope loop. The patient had an uncomplicated postoperative course.

DR. WILLIAM BRAND: The excretory system was normal bilaterally in urogram performed in 1961 and in 1967. The oblique projection in both examinations suggested a possible radiolucent filling defect in the dome of the bladder. However, so many irregularities are seen in the dome of the

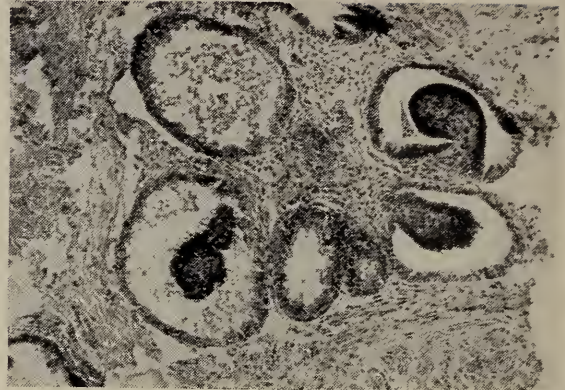


Fig. 1. Section of bladder wall contains endometrial glands and stroma characteristic of endometriosis of urinary bladder.

bladder in women that this would ordinarily be disregarded.

DR. JOSEPH SHERRICK: Fig. 1 is a section through the wall of the bladder. Peculiar looking glands are present in the submucosa and even as deep as the muscle in some places. Secondary gland formation is present. In association with these groups of glands are spindle shaped cells loosely arranged. This combination of glands and stroma is characteristic of endometriosis of the urinary bladder. I am a little surprised that the glands are this active in a patient who has no ovaries, but I expect the administration of Premarin accounts for it.

DR. JOHN BEAL: Dr. Stuart Abel from the Department of Obstetrics and Gynecology is here to discuss some of the clinical aspects of endometriosis and how it develops. I think we ought to know something about this disease. How does it spread?

DR. STUART ABEL: I agree that we should know more about it than we do. There are three main theories concerning the origin and dissemination of pelvic endometriosis. Each of the theories fails to explain all of the clinical problems. The theory of Sampson implicates retrograde flow of blood and endometrial fragments with implantation in the pelvis. Another theory postulates metaplasia of celomic epithelium. Islands of Mullerian tissue have been suggested as the site of endometriotic lesions. Under the influence of estrogens, they subsequently develop into islands of aberrant endometrial tissue.

By definition pelvic or external endo-

metriosis is a condition whereby islands of aberrant endometrial tissue are found almost anyplace in the pelvis or abdomen, thus creating confusion in urology or in general abdominal surgery. We have all stumbled over problems arising from endometriosis more than a few times. Both services, ours and the general surgical service, have erred on occasion. This interested me a few years ago because in the space of six days we had two cases we operated upon with a diagnosis of acute appendicitis and both were pelvic endometriosis with spillage. And those weren't the first two I had seen. We put together 12 cases in a relatively short time. The first was passed back and forth between the gynecological and the surgical services as to whether there might be some spill from endometriosis or whether there was a gall bladder problem. She finally wound up having her gall bladder out and the problem turned out to be gynecologic. It is always embarrassing to turn our patients over to the surgical service with a diagnosis of endometriosis subsequently made. Did I understand correctly that this patient we just discussed had been on Premarin? This perhaps might stimulate her endometriotic tissue. Endometriosis is a very difficult subject to teach, perhaps because there is so much about it we don't know and because of its protean manifestations. It is a disease that seemingly is on the increase, or at least it is seen now with much greater frequency than it was in the 1920's when Sampson made his initial observations. I remember asking Dr. Arthur Curtis if he felt that maybe we were just looking for it more, and if cases that had previously been interpreted as P.I.D. might have been endometriotic lesions. He said very definitely no. After he had heard Sampson's classic talks on the subject, he came back and counted exactly three cases of endometriosis that next year. As you probably know, at Wesley it was discovered that just about 50 per cent of the patients on whom abdominal laparotomies were performed had some degree of endometriosis. In some cases it was minimal and not the primary pathology, but it was that common. In that group of cases where there was considerable confusion in the differential diagnosis involving endometriosis, the mistakes were occasionally made primarily on the surgical service and occasionally on the gynecologic service. Fol-

lowing is a typical example of one of our mistakes.

The patient was a 43 year old divorcee who entered the hospital at ten o'clock on January 9th complaining of moderately severe abdominal pain localized in great part to the right lower quadrant of the abdomen. She stated that shortly after noon of that same day she experienced the onset of a generalized abdominal pain and some nausea. She vomited two times and had eaten nothing since breakfast. The pain had continued to increase during the afternoon and gradually localized to the right lower quadrant of the abdomen. There was no constipation or diarrhea reported. On admission to the hospital abdominal examination revealed some rigidity of the lower right rectus muscle, some generalized tenderness to palpation on the right lower abdominal quadrant. There was definite rebound tenderness referred to the right lower abdominal quadrant. The patient's temperature was 99.6° and her white blood count was 20,200. *A record of a preoperative rectal or vaginal examination did not appear on this patient's chart.* Urinalysis revealed no abnormality. The impression was acute appendicitis and the patient was prepared for operation. At surgery there was much free fluid in the peritoneal cavity, bilateral endometriotic chocolate ovarian cysts of orange size and a normal appendix was found. This white count was a little high, and this is one thing which we found consistent in most of these cases. I'm not going to bother to read all of them to you, but this picture was misinterpreted 12 times. I think that the point here is that anybody who is doing abdominal surgery, whether he's a gynecologist or general surgeon, has to keep in mind that endometriosis can produce an acute picture from spill of this chocolate tarry cyst, which is very irritating to the peritoneal cavity. It certainly can make a picture resembling appendicitis in many instances we have seen.

DR. FREDERICK LLOYD: This is indeed a very uncommon lesion in the urinary bladder, and whenever it appears a report is indicated. I have been very fortunate in the past 35 years. During this period I have seen six cases of endometriosis involving the urinary tract, five of the bladder and one of the lower ureter. The one involving the ureter was rather interesting and cau-

sed ureteral obstruction. The cause was obscure. When exploration was performed we found the ureter almost entirely occluded by a mass which was excised. The ureter was reimplanted into the bladder after making a Boari flap, which consists of taking a wide strip of bladder and constructing a tube of it to provide proper length and implanting the ureter in this. When this lesion was examined histologically it proved to be endometriosis.

About 15 years ago we had a patient, a former WAC, at the Hines hospital. She had a lesion in the bladder that was about 4 cm. in diameter and had the appearance of a cluster of grapes, the typical bluish-purple appearance of endometriosis. This lesion was so large that a segmental resection of the bladder was performed, and the gynecologist accomplished a complete hysterectomy and bilateral oophorectomy. This woman made an uneventful recovery and remained well. About two years ago here at Passavant we encountered a lesion that was typical of endometriosis at the cystoscopic examination. It was small and biopsy with a cup forceps was difficult because the lesion was confluent with the surface of the bladder. The resectoscope loop was employed and caused charring, thus making histologic examination unsatisfactory.

An interesting point is presented by the patient who was discussed today. She was suspected of having endometriosis before cystoscopy. When she had the complete hysterectomy and the bilateral oophorectomy in 1954 she was found to have endometrial implants and the operation was thought to have controlled this problem.

The history of the ingestion of Premarin was not obtained until after she had been examined and the nature of the lesion determined.

DR. JOHN BEAL: Dr. Lloyd, I gather that the lesion is typical when visualized through cystoscope. Isn't one of the characteristics of endometriosis hematuria at the time of menses?

DR. FREDERICK LLOYD: Yes, that is very typical. This did not occur here, naturally, because of her previous surgery. But on several occasions when we have had these patients they would develop this hematuria just when the menstrual period was occurring, just prior to the onset of the menstrual period. They would bleed at that time. This is a very important diagnostic point.

DR. JOHN BEAL: It is interesting to speculate as to how that endometrial tissue gets to the bladder.

DR. STUART ABEL: Endometriosis can be found in the appendix, the bladder, the navel, small bowel, large bowel, and scattered through the peritoneal cavity. It is obvious that no single theory can explain the presence of endometriosis in all cases. In most patients endometriosis does not involve the mucosa of the intestine. Is this found in bladder endometriosis?

DR. FREDERICK LLOYD: In the cases that I have seen, the lesion was fairly confluent with the bladder wall and did protrude into the bladder. The little bluish grape-like cysts of bladder endometriosis are superficial in the bladder. However, it is likely that they originate on the outside of the bladder and gradually invade. This resembles endometriosis of the colon.

EXERCISE PROMOTES COLLATERAL CIRCULATION

The experimental results reviewed here strongly suggest that during the early stage of the atherosclerotic process, exercise may be of particular value in promoting the growth of collateral vessels. Inasmuch as most middle-aged American men appear to be in this early and, at present, invisible stage of the disease, it appears imperative to encourage asymptomatic middle-age men to exercise. Through a program of exercise falling just short of anginal pain, collateral circulation may also be developed in patients who have had a recent coronary attack. While the benefits of surgical therapeutic measures may be desirable in certain cases, it would appear that a program of exercise started early enough and properly conducted might make other curative measures unnecessary in many cases. Obesity, Cardiovascular Diseases, and the Dietitian. Jean Mayer, Ph.D., D.Sc., *Jl. Am. Dietet. Assn.* (Jan.) 1968, pp. 13-20.

Medical Progress in Pediatric Urology

Apparent Ureteropelvic Junction Obstruction Caused By Vesicoureteral Reflux

BY LOWELL R. KING, M.D./CHICAGO

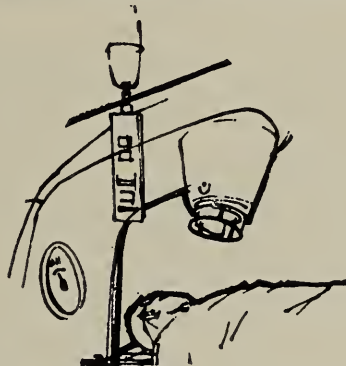
There are several well recognized distinct causes of ureteropelvic junction obstruction. These include intrinsic structure, high insertion of the ureter into the renal pelvis, obstruction due to an aberrant vesicular artery or vein passing to the lower pole of the kidney anterior to the ureteropelvic junction and combinations of the lesions. In each instance, the diagnosis is established when the renal pelvis and calyces are seen to be hydronephrotic on intravenous pyelogram, while the ureter, usually visualized by retrograde pyelography, is of normal calibre. Further studies, e.g. aortography to demonstrate an aberrant artery, are generally unwarranted, since the presence of calcinosis is an indication for surgical intervention, and since each of the lesions described above can be dealt with when the kidney has been exposed at surgery.

In general, an attempt is made to preserve the affected kidney unless the parenchyma is very thin. Stenosis of the ureteropelvic junction (UPJ) may be bridged by Foley Y plasty, dismembered ureteroplasty with excision of the stenotic segment, or intubated ureterotomy. When the upper ureter is atretic and the stenotic segment is several centimeters in length, a "spiral" flap of renal pelvis may be turned downward to enhance the calibre of the structured ureteral segment. High ureteral insertions into the pelvis, with or without concomitant ureteropelvic junction stenosis are easily treated by anastomosing the upper ureter to the adjacent pelvis or by dismembered ureteropyeloplasty. An aberrant vein passing anterior to the ureteropelvic junction may safely be divided. Division of an aberrant artery, however, results in ischemia and infarction of the renal substance supplied by this vessel, with some risk that hypertension will develop. Aberrant arteries are therefore best treated by transection of the renal pelvis cephalad to the artery. The ureter and pelvic stump

are then passed anterior to the vessel where the continuity of the urinary tract is then restored by pyelopyelostomy. If concomitant stenosis of the ureteropelvic junction is present, the stenotic area is, of course, excised, and continuity re-established by ureteropyelostomy (dismembered ureteroplasty).

Hutch has recently pointed out that vesicoureteral reflux may give rise to pyelographic changes that mimic those seen in the presence of ureteropelvic junction obstruction. There are two reasons why it is important to recognize reflux as a cause of hydronephrosis without hydroureter: 1)

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

the primary disorder, the reflux, is caused by derangement of the ureterovesical junction and cannot be corrected thru most incisions used to explore the kidney and 2) some causes of reflux tend to correct themselves with growth or after eradication of urinary tract infections. In these instances, operation may often be avoided altogether.

The purpose of this paper is to present several illustrative examples of "pseudo-ureteropelvic junction obstruction due to reflux and to illustrate how this disorder



Fig. 1A. IVP in a nine and one-half year-old boy presenting with traumatic hematuria. Hydronephrosis is confined to the lower collecting system of the right kidney.

may be managed. Preservation of renal function is the primary consideration.

Case Presentation:

J. W., a nine and one-half year old boy presented with gross hematuria after being knocked off his bicycle by a car. He appeared otherwise uninjured. Vital signs were stable. An intravenous pyelogram (IVP) was obtained, revealing duplication of the collecting system of the right kidney with hydronephrosis of the lower segment. (Fig. 1A) No ureterectasis was noted in the four film IVP series. The patient remained stable, and hematuria diminished. A cystogram revealed free reflux into the ureter draining the dilated renal segment (Fig. 1B). Cystoscopy revealed that the orthotopic right ureteral orifice, draining the lower renal segment, was gaping, thus permitting the reflux. The orifice draining the upper right kidney was normal, with an intravesical ureteral segment adequate to prevent reflux. Since the refluxing ureteral orifice was grossly abnormal, it did not appear likely that the reflux would stop with growth or "maturation" of the

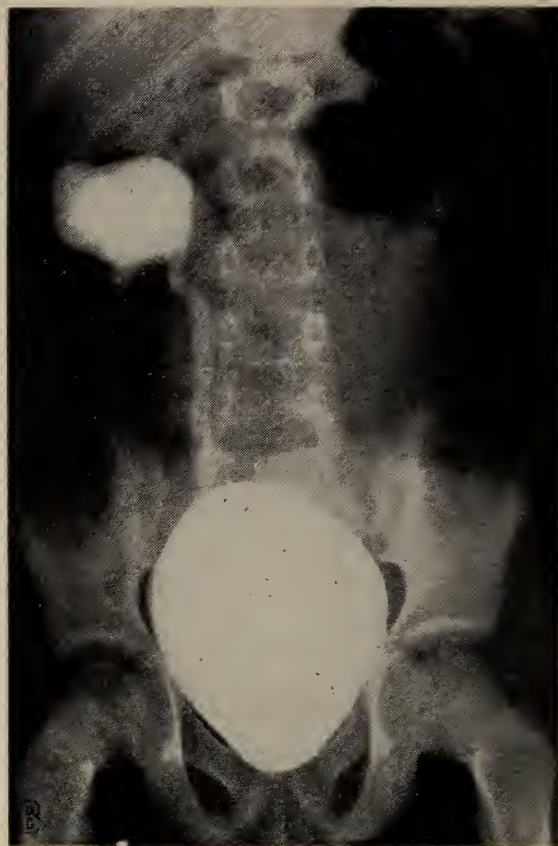


Fig. 1B. Cystogram on the same patient. Free reflux is present to the lower right renal segment. Moderate ureterectasis is present. The dilated pelvis of the lower renal segment was anastomosed to the adjacent normal ureter draining the right upper renal segment. The refluxing ureter was excised.

intravesical ureter. The relatively severe degree of hydronephrosis was also an indication for surgical correction. In this instance, the dilated renal pelvis of the lower portion of the kidney was anastomosed to the adjacent normal ureter draining the upper pole. The refluxing ureter was then excised. A good result was achieved.

Case Presentation:

M. M., a four year-old girl suffered repeated urinary tract infections. An IVP, obtained elsewhere, revealed left sided hydronephrosis (Fig. 2A). The ureter was not seen. She was admitted with the tentative diagnosis of left sided ureteropelvic junction obstruction. In all such patients, x-ray visualization of the ureter is desirable in order to be certain of the lesion and the level of obstruction. Accordingly, cystoscopy was performed. The left ureteral orifice was at once seen to be abnormal in that it was situated slightly lateral and above the usual position. It was also a wide orifice, and catheterization revealed that



Fig. 2A. IVP in a four year-old girl presenting with recurrent urinary tract infection. Calyectasis and a full renal pelvis on the left side suggested ureteropelvic junction obstruction.



Fig. 2B. At cystoscopy, the ureteral orifice appeared to permit reflux. A retrograde pyelogram confirmed the presence of ureterectasis.



Fig. 2C. The left sided reflux is demonstrated on cystogram. The patient was rendered free of infection and followed.



Fig. 2D. One year later, an IVP shows resolution of hydronephrosis. A repeat cystogram revealed cessation of reflux.

the intravesical ureteral segment was shorter than normal, being an estimated five mm. in length. It appeared that the ureteral orifice was of the type that might permit reflux. Retrograde pyelography revealed ureterectasis as well as hydronephrosis (Fig. 2B). The next day, a cystogram confirmed the presence of reflux (Fig. 2C). Since a partial "flap" was present over the refluxing ureteral orifice, and since some further increase in the length of the intravesical ureter seemed probable with growth, immediate operative correction of the reflux was not elected. Bladder outlet obstruction had been ruled out. Urinary infection was eradicated by specific chemotherapy, and the patient was seen frequently for urinalysis and culture to be certain that infection did not recur. She remained well. A repeat cystogram, made about one year later, showed no reflux. An IVP at that time showed resolution of hydronephrosis. Calyectasis had disappeared (Fig. 2D). The patient has remained well.

Case Presentation:

D. K., a boy, was eleven months of age when first seen. He had exhibited a persistent feeding problem throughout infancy. A urinary tract infection was the reason that an IVP was obtained. This examination revealed bilateral hydronephrosis, very severe on the right side and of moderate degree on the left. The ureters were not seen. A cystogram revealed bilateral reflux, but showed only a mild degree of ureterectasis bilaterally. Function studies substantiated the impression that renal function was diminished. Because of this, and because of the severity of the right sided hydronephrosis, operative correction of the reflux was elected. Both ureters were reimplanted into the bladder on anti-reflux technique. Following operation, hydronephrosis resolved completely in the better left kidney and diminished in degree on the right side. Urinary tract infection has been eradicated.

Case Presentation:

K.B., a six year-old girl, presented for evaluation because of recurrent urinary tract infection. Left sided hydronephrosis was evident on IVP. A cystogram showed left sided reflux (Fig. 3A). As with the previous patient, the degree of ureterectasis seems disproportionately slight relative

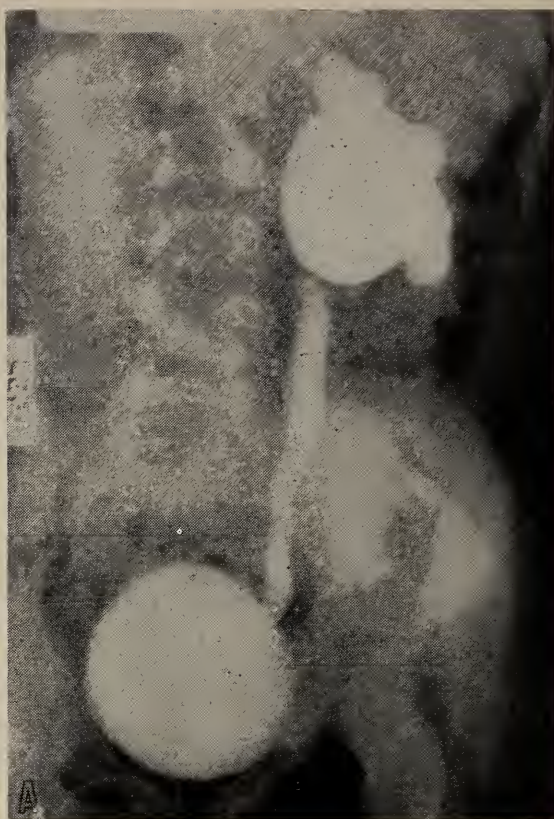


Fig. 3A. Cystogram of a six year-old girl presenting because of repeated urinary tract infection. An IVP showed calyectasis and a large renal pelvis on the left side. Note that the pyelocalyectasis is relatively greater than the degree of ureterectasis.

to the degree of hydronephrosis. At cystoscopy, the refluxing ureter proved to empty into a congenital bladder diverticulum (not evident on the cystogram). Since reflux due to this etiology is static and does not tend to improve with growth, ureteral implantation into the bladder was performed. A post-operative IVP (Fig. 3B), shows complete resolution of hydronephrosis.

Discussion

It is apparent that hydronephrosis without hydroureter, as seen on IVP, may be due to vesicoureteroreflux as well as obstruction at the ureteropelvic junction. A normal ureter must be visualized below the UPJ to substantiate the diagnosis of obstruction at that level. Reflux as a cause of such hydronephrosis can be ruled out by avoiding cystourethrogram, an examination which should probably be performed upon all patients with apparent UPJ obstruction. When reflux is the cause of hydronephrosis, treatment depends primarily upon the etiology of the reflux. Reflux due to a



Fig. 3B. Following ureteral reimplantation, the left upper tract returned to normal on IVP. A post-operative cystogram showed no recurrence of reflux.

paraureteral diverticulum (congenital, or secondary to bladder outlet obstruction), to overt outflow obstruction alone, or to a gaping ureteral orifice will generally require operative intervention for relief of obstruction and/or ureteral reimplantation by an anti-reflux technique. On the other hand, reflux due to an intravesical ureteral segment which is shorter than normal may cease when the intravesical ureter lengthens. Reflux may also stop after eradication of infection. When reflux is expected to diminish, the patient may be followed with the expectation that upper tract dilation will decrease when the reflux stops. Bladder outlet obstruction must be ruled out

in patients treated in this manner, and careful follow-up is necessary to be certain that potentially damaging infection does not recur. Frequently recurrent or persistent urinary tract infections are themselves an indication for the operative correction of reflux.

Summary

Vesicoureteroreflux is a cause of hydronephrosis without ureterectasis on intravenous pyelogram. Such pseudo-ureteropelvic junction obstructions must be differentiated from obstructions near the kidney, since treatment depends on the cause of reflux, and operative therapy must be directed to the ureterovesical, not the ureteropelvic, area. Four illustrative patients are presented with a resume of management in each instance. The cornerstone of treatment is preservation of renal function. The management of vesicoureteroreflux is discussed briefly.

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BASE OF MEDICINE

"A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent learning as distinguished from mere skill.

It is an occupation which is pursued largely for others and not merely for one's self. It is an occupation in which the amount of financial returns is not the accepted measure of success."

Justice Louis D. Brandeis.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Clinical Professor of Radiology, Chicago Medical School*

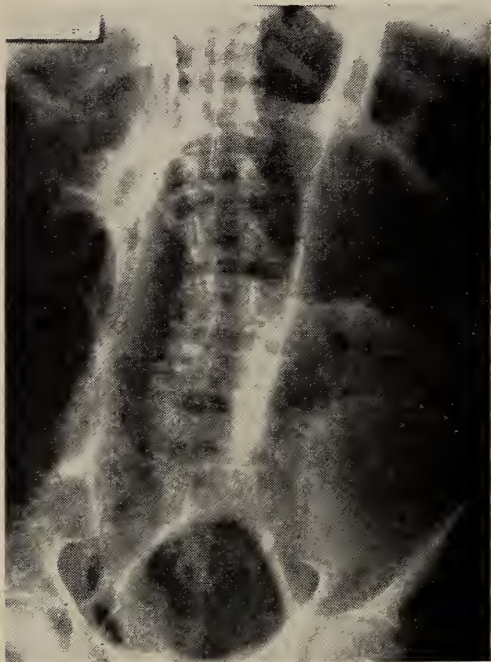


Fig. 1

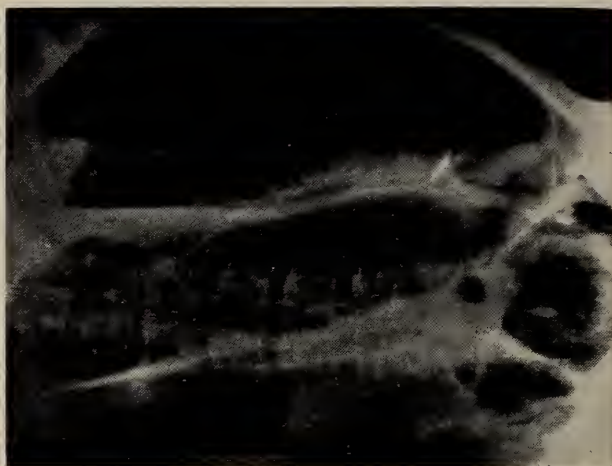


Fig. 2



Fig. 3

This 65 year old male entered the hospital with a 4 day history of intermittent diffuse abdominal pain which had suddenly increased in intensity. He also felt that his abdomen was "swelling up." He had not moved his bowels for the last day. Physical examination revealed the abdomen to be markedly distended with moderate amount of tenderness present.

WHAT'S YOUR DIAGNOSIS?

- 1) Carcinoma of the sigmoid
- 2) Toxic Megacolon
- 3) Sigmoid volvulus
- 4) Cecal ileus

(Answer on page 766)

Historical Sketch of Psychiatry In Illinois—1940 to 1968

BY KATHARINE W. WRIGHT, M.D./CHICAGO

The historian may be factual only or utilize facts as a basis of presenting a picture of the state of affairs at the time of writing. Since my advent into psychiatry in Illinois was at Elgin State Hospital in 1940, this will be the beginning of this historical sketch.

Meager resources and opportunities for training and experiences in psychiatry prior to 1935 are noted in Dr. Hugh Carmichael's paper.¹ He states that there was a Mental Hygiene outpatient clinic at Michael Reese Hospital in that year and also a limited residency training program was set up. The next decade witnessed enlargement and improvement of these programs. It is also noted that the Illinois Psychiatric Society was not started until 1939.

To return to Elgin, and what I found: Although under Dr. Charles Read's administration with Dr. Eric Liebert, Clinical Director, Elgin offered an excellent training for psychiatrists aspiring to become certified by the Board of Neurology and Psychiatry. Many of the methods of treatment were less progressive. One example is the use of "sulphur-in-oil fever therapy,"



started in 1931 and continued in use through 1942. Huge intramuscular injections were given to the dementia praecox (terminology then in use) patient over a period of several months, with results as recorded on a series of 40 cases showing temporary improvement of ward behavior. As typical examples:

BETTY B.

Very combative, untidy, destructive, uncooperative, large physique and dangerous to other patients and employees, *at all times.*

During treatment and for a short time afterwards as shown by treatment record, is manageable without so many injuries to others.

COURSE OF TREATMENTS

11-20-40 to 12-4-40)	
8 treatments)	
2-4-41 to 2-20-41)	
8 treatments)	5 month period
3-25-41 to 4-8-41)	
7 treatments)	
)	
)	

ALEXANDRA A.

Patient received from C-3-N "Combative Ward."
Untidy, continual trying to get outdoors.
History of eating excreta.

After treatment—Patient works in day room, combs all patients' hair, washes windows, is not untidy, good worker.

COURSE OF TREATMENTS

11-20-40 to 12-6-40)	1 Course
)	5 month
8 treatments)	period

A "Follow-Up Study of 100 Cases" was made at Elgin at this time, with the suggestion that some type of "Half-Way Houses" for discharged State Hospital patients be established, but my voice was too weak in 1942 to reach legislators and mental health authorities. Today, certain homes under state psychiatric supervision are available to improved patients, and the State Rehabilitation Division of the State Department of Public Welfare offers counselling for job training and placement.

Other methods² were Insulin Treatment, introduced by Sakel in 1938, Metrazol by Meduna in 1934, and electric shock therapy introduced in 1938 by Cerletti and Bini. These treatments were used extensively with varying results; some patients showing only behavior improvement and others longer-lasting benefits.

In 1942, four cases were selected at Elgin, after physical and psychological tests, to undergo the treatment highly recommended by Dr. Walter F. Freeman, Washington, D.C., "Pre-frontal Lobotomy."³ Of the four cases (all regressed schizophrenics), three made temporary improvement and the fourth died post-operative. This research study was discontinued. Also at this time a program of training and clinical experience for theological students was inaugurated by Anton T. Boisen, D.D., and was the seed for an effective program today.

Occupational Therapy

During this period, the Insulin Therapy Ward was under the direction of Dr. Gerhart Piers, presently the Director of the Psychoanalytical Institute. Although the insulin treatments were effective there was no occupational therapy available for patients in this section, who spent most of their afternoon in idleness. To me there

seemed a great need for activity, and with the encouragement and the cooperation of Dr. Piers, the O. T. Department set up a good program in which these patients gratefully participated.

The second new program in Occupational Therapy was introduced in the ward where the "escape patients" were housed, and it was surprising the interest that was created. A third group, brought into this program through my efforts, was in the cottage of 250 women who were classified "regressed patients"—mostly diagnosed dementia praecox, and this was accomplished by setting off one end of the room, behind benches, for the few patients who were able to participate. Some unravelled gunnysacks but a very few became more interested and one active manic-depressive patient was able to fashion hats out of colored scraps and, later, together with other treatment, returned to her profession as a milliner.

Recreational programs were also active at this time and many patients profited by them. At a cottage of 80 patients, diagnosed as dementia praecox, all under the age of 35, the only activity that interested them was roller skating. It seemed, from clinical observation, that the motion without the need of contacting any other person was an emotional outlet for these individuals. However, it did not increase their verbal communication, showing the need for research in this field.

'Conditional Discharge' vs. 'Parole'

In 1942, Dr. Robert J. Jacobson asked me to join him in demonstrating his new technique of non-verbal group therapy,⁵ using many withdrawn, uncommunicative patients in weekly sessions for a period of one year. Surprising results were obtained



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in stimulating outbursts of verbalization. A few patients, who formerly had been treated by one of the previously mentioned procedures, were placed in a second group. Here further improvement occurred and they were among patients paroled (term then in use) from the hospital. The term "conditional discharge" has replaced the former one of "parole," indicating a better attitude of public officials.

From this start, a modified form of the non-verbal method was used with discharged or conditionally discharged patients at the Community Clinic. Group therapy then occupied my time and thoughts for the next several years, stimulating the development of other programs. A group approach to weight control, at the YWCA, outlined in an article, "Psychiatric Aid for the Obese,"⁷ was the next development. Tape recordings of the sessions were made and after a two year period they were used by a small follow-up group meeting in my private office. Private group practice was then in its infancy, whereas now it is an armentarium of widespread use.

Veterans Out Patient Clinic

During the same year, 1946, I was offered the position of Senior Psychiatrist on a part-time basis at the Veterans Mental Hygiene Outpatient Clinic. Here, as the first woman psychiatrist, many battle neuroses and other types of severe anxieties were treated. The experience gained in the management of such a clinic was utilized later in the planning of the Mental Hygiene Clinic, Womens and Children's Hospital.

World War II gave impetus to the acceptance of group therapy and several methods were used—such as puppets, role-playing, and discussion groups. From this beginning there has been rapid extension of group therapy treatment.

In order to standardize group therapy and make it of value, a group of interested therapists developed an Illinois Group Psychotherapy Society which was chartered on Nov. 19, 1964. My interests led me to accept responsibility as a member of the Steering Committee. This organization is now presenting good programs and workshops to train and stimulate younger therapists for group therapy.

Therapy For Married Couples

The most recent developments in this therapeutic modality has been Married Couples Group Therapy, conducted at the Katharine Wright Mental Health Clinic, Stone-Brandel Center. Sociologic changes occurred and at times a shift in emotional balance between the couples was the result. Because of psychological insights, changed attitudes, need to maintain the family unit and better interpersonal communication, all couples thus treated remained in the marriage. Of the three years spent with married couples groups, two years were with me as leader, and one year with Dr. Warden Rimel as co-leader. In each group five couples participated.

From Elgin, the next opportunity open for me was a three-year Northwestern University Medical School Teaching Fellowship under Dr. Francis Gerty, at Illinois Neuropsychiatric Institute. The Director of Illinois Neuropsychiatric Institute supervised the student program. My part was teaching the junior medical students in the outpatient clinic and in seminars on the Ward, as well as assisting Dr. Clarence Neyman with the seniors for a three-hour Saturday morning session given at the Psychopathic Hospital, now known as the Mental Health Clinic.

After finishing my apprenticeship with Dr. Clarence Neyman, I sought hospital facilities and was accepted on the Wesley Memorial Hospital Courtesy Staff in 1946. He also recommended Fairview Sanitarium, as it was then known, and I joined the staff in 1946. Fairview Hospital emphasized active treatment to hasten the discharge of patients. It was the first private psychiatric sanitarium in Illinois to receive hospital accreditation, as well as first private psychiatric hospital to be accepted by the Blue Cross-Blue Shield Plan, in the year 1958.

Influx of Tranquilizers

The Fairview Hospital has pioneered in the application of the new psychiatric somatic modalities which had made their appearance in the late thirties, and as a result ushered in the era of modern psychiatry. As outlined in the article "Electro-Shock Therapy in Patients with Severe Organic Disease,"⁸ published in the Illinois Medical Journal February 1949, the use

of the newer techniques eliminated many of the previous contraindications and thus helped to spark the opening of psychiatric units in general hospitals. The influx of tranquilizers given by general practitioners as well as psychiatrists has been of inestimable aid to psychotherapy for post-hospital patients, as well as preventive medicine for those who are borderline hospital cases. Preventive psychiatry was in its infancy in 1945.

My interest in the preventive phase of psychiatry was intensified in 1946, when I was a member of the Staff at Mary Thompson Hospital and started their first outpatient clinic in psychiatry. In 1946, a survey of hospitals in Chicago was conducted by the Mental Hygiene Society, with the purpose of finding one available to meet a demanding need for outpatient mental health service. Mary Thompson Hospital presented the best plan for the future and so was chosen as the place to venture into a new type of service—the evening psychiatric clinic for women.⁹

Aims and Purposes of Clinic

The aims and purposes of the clinic can be simply stated: (1) to provide treatment for emotionally disturbed young women and to attain for them a more acceptable vocational, social, or family adjustment, or a combination of these three; (2) to provide low-cost treatment on such a basis that self-respect of the individual is maintained and her budget also considered; and (3) to provide evening hours so that treatment would not interfere with duties at home or at work.

The original staff consisted of three part-time psychiatrists, two part-time psychologists, and one full-time psychiatric social worker. We opened with ten cases and ended the first year having treated 189 patients in contrast to Sept. 1, 1962, when 142 patients were under treatment during that month alone. The clinic procedure as adopted had various aims in view—to expedite examination, to safeguard the physical case records, to promote adequate treatment by encouraging proper recording and staff discussion, and to conserve the therapist's time for psychotherapeutic treatment. Treatment interviews were held with the psychiatrist, psychiatric social worker, and/or psychologist.

Growth of Clinic

At first, publicity on the outpatient clinic was curtailed, as this was a pioneer movement and one which would have to move slowly. On the other hand, as this was in some ways a demonstration project, the work was so planned, regarding records and statistics, that it could provide research in the future. At the same time, it would adhere to its primary goal of patient treatment in a city where psychiatric clinical facilities were set up chiefly for teaching and research.

With the present patient load, additional staff has been added and fees somewhat increased. From this early beginning in 1947, the numerical growth of the clinic has been steadily increasing. At the present time, January 1968, the staff composition is as follows: (all part-time employees, except secretarial staff) 23 psychiatrists, five psychologists, one psychodramatist, six psychiatric social workers and six psychiatric consultants. Prior to opening the clinic, an advisory committee of outstanding professionals was appointed to serve as a liaison with the public, and this group greatly strengthened the clinic by their counsel.

Orientation Group Formed

The number of patients treated in January 1968 on a group and individual basis in the Katharine Wright Mental Health Clinic was approximately 325, with a small waiting list. To avoid waiting longer than a week or 10 days, an orientation group has been formed. Each applicant meets once in this group with the psychiatric social worker and a staff psychiatrist to explain clinic procedures and elicit motivation of prospective patients. After this, further appointments are made with another social worker, psychologist, or psychiatrist for further evaluation. With these reports, the director holds a conference with members of the staff involved in this case, and an assignment is made.

It must be added that since patients' fees amount to about only one-third of cost, the clinic's facilities would not be possible without the understanding, cooperation and steady financial support of the Illinois State Mental Health Department, as well as the supporting agency, the Stone-Brandel Center. The combination of patients' fees, Stone-Brandel funds, and State finan-

(Continued on page 760)

Dosages For Aqueous Allergy Injections

BY DONALD L. UNGER, M.D., DONALD E. TEMPLE, M.D.,
AND LEON UNGER, M.D./CHICAGO

While allergy extracts can give excellent results when used properly^{1,2}, they are potent and must be treated with respect. We have found the following dosages to be safe and effective in most patients, but there are about as many schedules as there are allergists. The numbers should be guidelines not necessarily suited to a given patient, as there are many exceptions to the rules. We use weight by volume and are not discussing protein nitrogen units (P.N.U.) used in various parts of the country.

Starting dosages are determined by the size of the skin tests, history of reactions to previous hyposensitization, and the presence or absence of atopic dermatitis (which implies a greater risk of reactions). Most patients begin at 1:100,000 or 1:10,000 dilutions. If a patient is having reactions to dilute extracts, he should not be raised to stronger concentrations, but one should try to have every patient reach his maximum

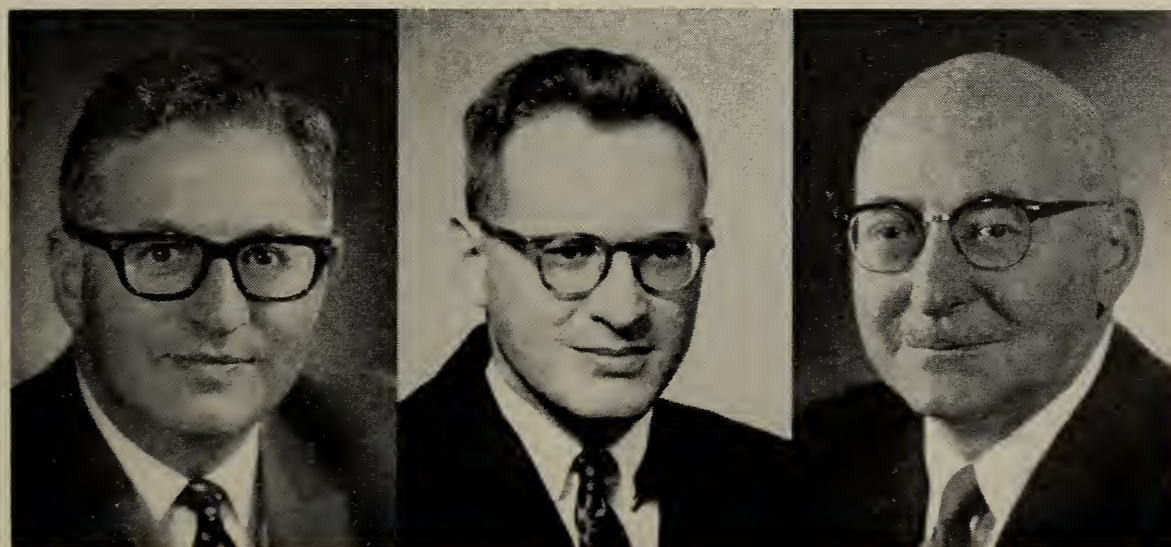
tolerated level. The following dosages apply to dilutions of 1:1000 or weaker:

1:100,000	1:10,000	1:1000
0.10cc	0.10cc	0.10cc
.15	.15	.15
.22	.22	.22
.30	.30	.30
.45	.45	.45
0.65cc	0.65cc	0.85cc

Thus, after a patient receives 0.65cc of a 1:100,000 dilution, he is given 0.10cc of 1:10,000.

Systemic reactions (hives, asthma, etc.) are most likely to occur when changing from a 1:1000 to a 1:100 solution, so extreme care is necessary at this point. The 1:100 solutions are raised a maximum of 0.05cc and the concentrates (3% to 10%) and vaccines 0.01cc at a time. Dosages are increased at less than 24-day intervals, unchanged at four weeks, and decreased at longer intervals. The amount of decrease depends on the

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time since the last injection, concentration of the solution and history of past reactions. Patients start injections twice weekly, receive them once a week while on 1:1000 solutions, every two weeks on 1:100, and every three weeks while receiving concentrated extracts. Patients are kept in the office for fifteen minutes after injections.

Exceptions

1. Patients who have had systemic reactions in the past are raised cautiously.

2. Dosages are unchanged after a small local reaction, lowered slightly after a large local, and decreased to about a tenth of the original dose after a systemic reaction.

3. Endo house dust is best started at 1:1 million and the 1:1000 solution should be used as a concentrate.

4. Dosages of weak solutions can be doubled for patients who have received concentrated extracts in the past.

5. Pollen dosages are cut about 25% during their pollinating seasons, e.g. ragweed in August and September.

6. When new extracts replace old ones, dosages are cut about 25%, as they are not always equally potent.³

7. Patients with atopic dermatitis should be raised more carefully than other patients.

8. During pregnancy, injections are given every four weeks and dosages are kept constant.⁴

9. Injections are not given when the patient has a fever⁵, but are given when he has a cold. (Some allergic patients always have a "cold").

10. The most concentrated part of a mixture, e.g. dust 1:10,000 and fungus 1:100, determines the dosage used.

Causes of Systemic Reactions

1. Ignoring repeated local reactions.

2. Raising pollen dosages during the pollinating season.

3. Raising dosages after a prolonged interval, e.g. three months.

4. Raising eczema patients too rapidly.

5. Giving the same injection twice. A bottle that has been used should be placed well away from those about to be used.

6. Using the wrong bottle, e.g. ragweed 1:100 instead of 1:10,000. Also, beware of confusing Oriental patients with similar names; Orientals are often exquisitely sensitive.

7. Not pulling back on the plunger, and injecting an extract intravenously.⁶

Summary

Hyposensitization ("desensitization") is generally safe and effective, but the extracts are potent and must be used carefully. We have found these methods and precautions helpful in the management of our allergic patients. This is not to claim, however, that other methods are less safe or less effective.

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The Roentgenological Aspect of Intra-Uterine Contraceptive Devices

BY GABRIEL E. CHAN, M.D. AND CARLOS REYNES, M.D./CHICAGO

With increasing popular use of the intra-uterine contraceptive devices, or IUCDs, the medical practitioner must familiarize himself with their various facets. It is the purpose of this paper to acquaint him with their roentgenological aspects.

IUCDs IN THE UNITED STATES

Currently there are four basic types of IUCDs in use in the United States: (a) the spiral (Fig. I,i,A) devised by Margulis,^{13,14} (b) the bow (Fig. I,i,B) designed by Birnberg,² (c) the loop (Fig. I,i,C) developed by Lippes,¹² (d) and the steel ring (Fig. I,i,D) credited to Hall and Stone.⁷

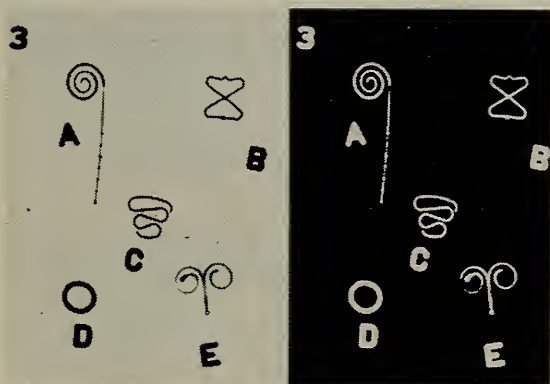


Figure I, i.
Phantom radiograph
of IUCDs
A. Margulia spiral
B. Birnberg bow

C. Lippes loop
D. Hall-Stone ring
E. Saf-T-Coil
Figure I, ii
Photographs of IUCDs
in I, i

The comparative merits of these IUCDs have been studied by Tietze,¹⁷⁻¹⁸ and R. Hall.⁹ A new device, Saf-T-Coil (Fig. I,i,E) is presently under clinical trial. Figure I, ii is the photograph of the foregoing IUCDs.

ROENTGENOLOGICAL FINDINGS

Localization

A patient is usually referred for roentgenological examination after IUCD insertion, at periodic check-ups, or because of

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various complications. An effort is made to determine its location. In the manufacturing of IUCDs a barium salt is added to the polyethylene material to permit X-ray visualization.

Roentgenographs of the pelvis in the antero-posterior and lateral projections, or a KUB in the antero-posterior and lateral projections are usually taken. In the views of the pelvis, an IUCD in the peritoneum after uterine perforation may not be demonstrated. For this reason, the authors prefer KUB in antero-posterior and lateral views in the routine examination. Figure II shows an IUCD in situ in the uterus.

Dr. Lehfeldt⁶ at Bellevue has a remarkable X-ray showing a "loop" in the uterine cavity, and another "loop" in the mid-abdomen. Several weeks after a symptomless uterine perforation occurred in the process of inserting a "loop," another "loop" was properly placed in the uterine cavity.

Expulsion

If the IUCD is not visualized within the uterine cavity in the radiograph, it is likely that it has been spontaneously expelled.

Uterine Perforation

If the IUCD is far removed from the uterine cavity and appears in the abdomen, a presumptive diagnosis of uterine perforation can be made.

Case I.: The patient was a 27 year old Negro female, Grav. VIII, Para. V, Ab. III, with complaints of intermittent, crampy abdominal pain since an IUCD was inserted four days prior to admission. There was no history of nausea, vomiting, fever, or chills.

Physical examinations were negative except for the following: The abdomen was soft and non-tender. The bowel sounds were slightly hyperactive. The uterus was slightly enlarged. The cervical os admitted a finger tip.

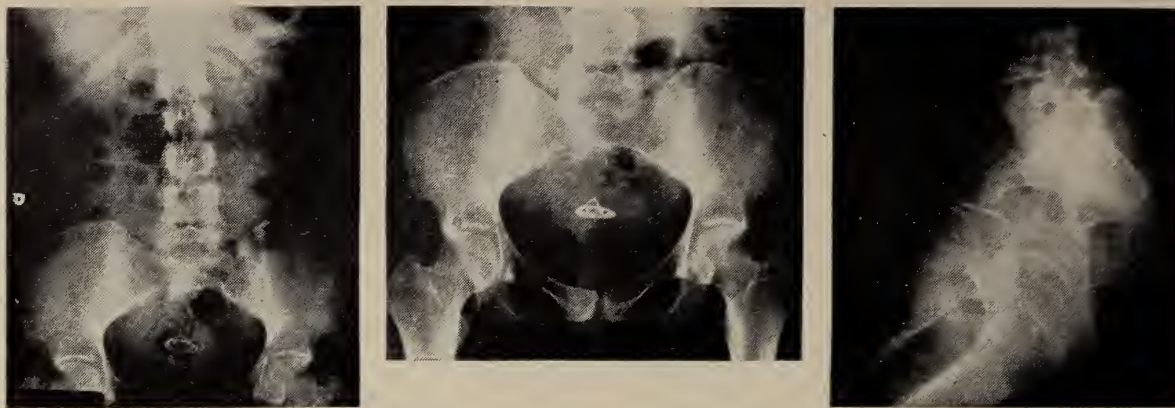


Figure II.
A. KUB (left), B. A-P (center), C. Lateral views of the pelvis with a "spiral" in situ.

Roentgenograms (Fig. III) illustrate a "coil" in the right abdominal cavity and a diagnosis of uterine perforation was made.

At surgery, the IUCD was removed from the peritoneal cavity. The perforated fundus of the uterus was repaired. Patient had an uneventful recovery.

Whether an IUCD is in the uterine cavity or not can be confirmed by hystero-graphy.³ This procedure is particularly useful in cases where only part of an IUCD has protruded beyond the uterine wall. Figure IV shows a hystero-gram with an IUCD in situ.

Case II.: 24 year old Negro female, Grav. V, Para. V, last delivery 14 weeks, and LMP 14 days prior to admission, complaints of crampy abdominal pain in the left abdomen after an IUCD was inserted two days before. No history of nausea or vomiting. Physical examination was negative except for slight tenderness in the left abdomen. Roentgenograms: KUB in A-P and lateral projections (not shown) reveal a "bow" in the left peritoneum. A diagnosis of perforation of the uterus was made, and was confirmed by hystero-gram (Fig. V).

At surgery, the bow was removed and the perforated fundus of the uterus was repaired.

Bowel Obstructions

In cases of intestinal obstruction in patients with IUCDs, one must be alert to the possibility of uterine perforation and subsequent intestinal obstruction. Price¹⁵

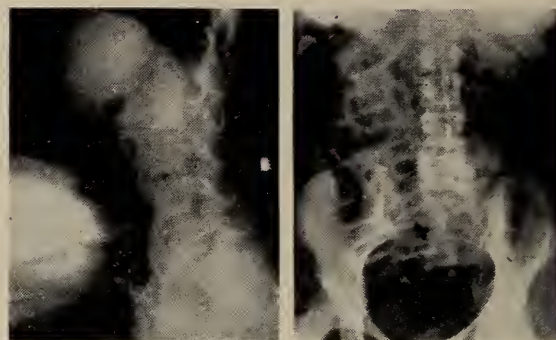


Figure III. An IUCD in right abdomen after uterine perforation, confirmed at surgery. A. A-P (left) B. Lateral view (right)

reported a case in which a Graefenberg ring had eroded through some two-thirds of the uterine wall and a loop of ileum had passed through the ring, resulting in intestinal obstruction. Seward, et al.¹⁶ reported a similar case with a Birnberg bow which had eroded half-way through the uterine wall. Approximately sixteen inches of ileum had worked its way through the protruding half of the Birnberg bow, causing small bowel obstruction.

Figure VI shows the probable mechanism producing bowel obstruction. In Figure VI A, peristalsis (indicated by arrows) propels a loop of small bowel into the protruding half of a Birnberg bow. In Figure VI B, further peristaltic movement (arrows) producing dilatation of the proximal loop secondary to mechanical obstruction. Note the air fluid level in the proximal loops, and the collapsed distal loop.

Pregnancy

Occasionally pregnancy occurs in patients with an IUCD in situ. Many proceed

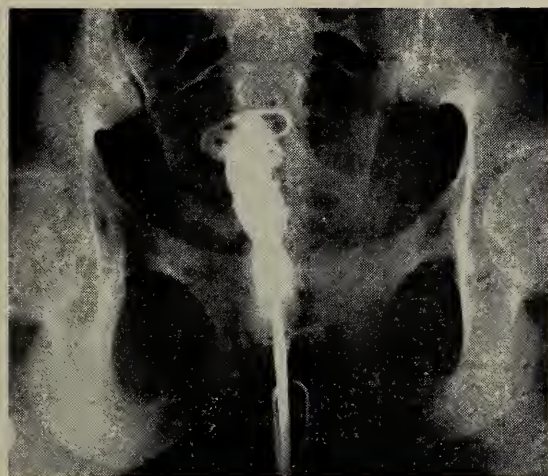
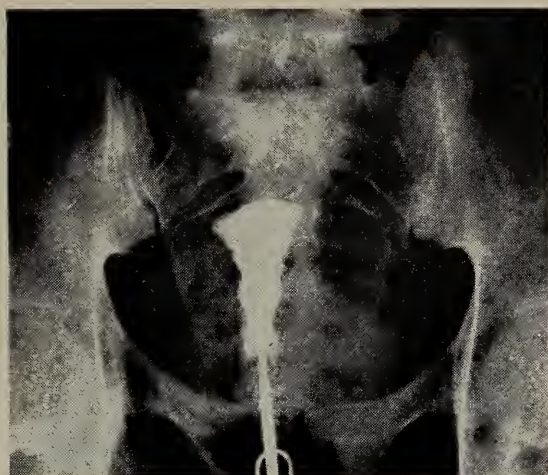


Figure IV. Hystero-gram with an IUCD in situ. (top to bottom)
A. and B. A-P views
C. Lateral view

to term with the birth of a normal infant.⁶ The device is always extraovular and is expelled with the placenta and membranes. The abortion rate is somewhat higher in these cases, while the prematurity rate is essentially the same.



Figure V. A bow in the abdomen post-uterine perforation, confirmed by hystero-gram and surgery.

There are no indications for therapeutic abortion⁶ if pregnancy occurs in patients wearing IUCDs. The device may be left undisturbed in such a situation, or if tailed and easily withdrawn, it may be removed. There is no justification in attempting to withdraw an untailed device by a hook in these cases.

Case III.: 21 year old Negro female, Grav. III, Para. II, LMP. five months prior to admission, comes to the outpatient clinic because of enlarging abdomen and cessation of menstrual period. Patient had an IUCD inserted six weeks after last delivery 19 months before. There is no history of bleeding, cramps, or pain. Physical examination reveals an enlarged uterus. The cervix was soft.

Roentgenograms (Fig. VII) show a "bow" displaced by fetal parts.

Patient had been followed in the prenatal clinic. Four months later, patient was delivered of a normal term infant. At delivery the IUCD was not found with the membranes. Follow-up radiographs reveal the IUCD still present in the pelvis.

Clinch⁴ reported a case of a married woman, age 26, who had been fitted with a Lippes loop, became pregnant and was delivered of a normal infant. The IUCD was not found in the placenta or membranes. X-ray showed that it was still in the uterus. Six months later hystero-gram shows no filling of the Fallopian tubes. The "loop" was subsequently removed under general anesthesia. D & C shows normal endometrium. Patient had an uneventful recovery.

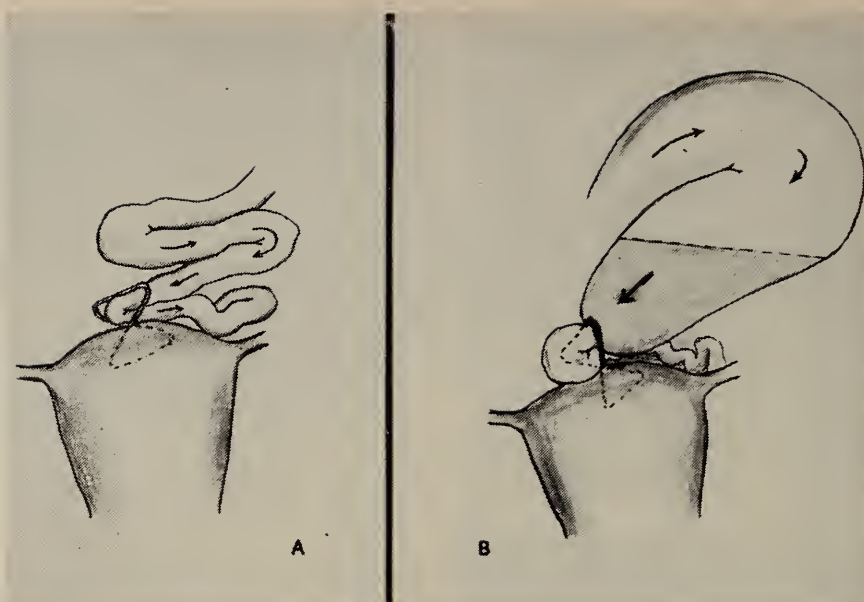


Figure VI. Shows the mechanism producing bowel obstruction. The IUCD has been eroded through the uterine wall. A loop of small bowel has worked its way through the IUCD causing mechanical obstruction.

Figure VII.
B. Late stage

Carcinogenicity

Another aspect of IUCDs of roentgenological interest is whether their application would induce cancer. Studies ^{8,10,11} have been conducted with negative results.

Since the IUCDs have little contact with the cervix or cervical canal, one would expect an IUCD to affect endometrial carci-

noma but not cervical carcinoma. Dr. Howard C. Taylor, Jr., Chairman of the Second International Conference on Intra-uterine Contraception, pointed out that endometrial carcinoma is rarely encountered before menopause, and is usually preceded by ovarian dysfunction rather than an irritative local cause.^{5,6}

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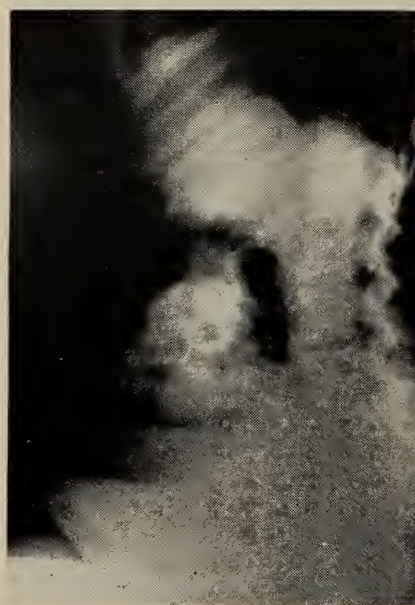
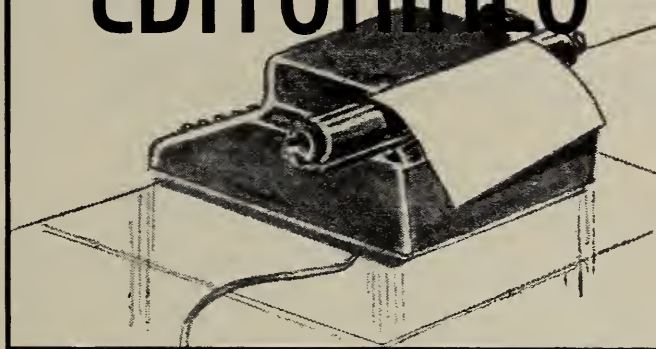


Figure VII.
OB abdomen shows an IUCD displaced by fetal parts.

A. A-P (left)
B. Lateral view (right)

EDITORIALS



THE MEDICAL MAN POWER CRISES— A SHORTAGE OF CHIEFS AND INDIANS

The problem of the delivery of health service to the people of our country is encountering increasing difficulties. A major bottle neck is the lack of adequate medical man power. The acute shortage of health personnel has adversely affected many of the government programs directed at the delivery of needed medical services to the disadvantaged. The severe shortage of health personnel in the rural sections of our country has been increasing for the past 30 years. This has been stressed recently by Dr. Elkanah Lahav, in the *New England Journal of Medicine*, who states that Maine has fewer physicians practicing now than at the turn of the century. This is true in many other sections of rural America. Experts estimate that over 5,000 communities throughout the country are in urgent need of physicians. He concludes that medical science has outstripped society's effectiveness in distributing the fruits of the most advanced economical medical knowledge to all its socio-economic class.

Unrealistic planning in terms of medical man power has occurred in recent legislation enacted by the federal government. Congress has appropriated the money, but no thorough investigation of the problem of finding trained personnel to carry out these projects has been carried out. This can lead to a tremendous waste of the federal tax dollar and great disappointment in the disadvantaged sections of the population who have rising expectations of health care.

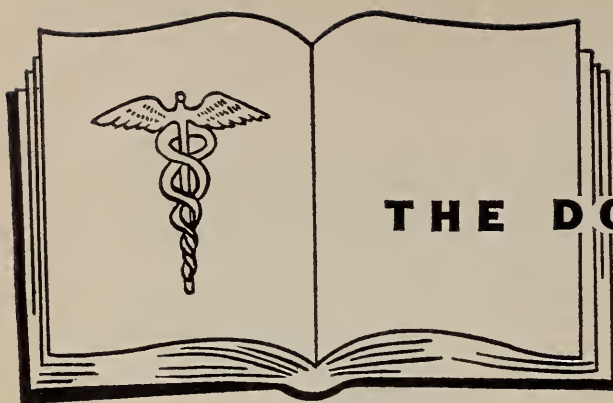
Perhaps the realistic criteria employed by

the National Institute of Health in approving grants should be applied to future health projects when a research investigator applies for a research grant. These questions have to be answered: Is the project worthwhile? Are there trained personnel to carry out the project? If the first two criteria are met and the trained personnel not available the project is disapproved. Improvement of the health services in our country cannot be solved by legislation alone. Long term planning for more physicians and other health personnel is urgently needed. This has been stressed in the recent recommendations of the Presidents National Advisory Commission on Health Man Power. This commission pointed out the great need for more medical, dental, and nursing schools and the expansion of loans to medical students.

What is being done in Illinois to solve the medical man power crises? There should be an expansion of scholarships for medical students who agree to practice for five or more years in designated areas in Illinois where there is an urgent need of physicians. Programs for increasing the enrollment of medical students in five medical schools in Illinois should be implemented as soon as possible. A new medical school in the southern part of Illinois would be helpful in alleviating the relative lack of medical services in this area.

Dr. Joseph A. Gallagher has aptly stated "man power is probably the secret to our nation's health in the years to come."

Harvey Kravitz, M.D.



THE DOCTOR'S LIBRARY

THE CARE OF THE PATIENT IN SURGERY, INCLUDING TECHNIQUES. 4th edition. Alexander, Burley, Ellison, and Valleri. The C. V. Mosby Company. St. Louis, 1967. 898 pages. 621 illustrations.

This textbook on the care of patients in the operating room is presented by four outstanding nurses. Mrs. Alexander and her colleagues are to be congratulated on the fourth edition of this book which covers all aspects of operating room nursing service.

The first seven chapters are concerned with the physical features of operating rooms, the administration of operating room nursing services, and other basic concepts, including sterilization, equipment, and maintenance of instruments.

The remainder of the 21 chapters are devoted to considerations of the methods employed in the basic surgical procedures that take place in the operating rooms.

The illustrations are well chosen, are pertinent to the chapters, and are comprehensive.

In general, the chapters are subdivided into sections which are related to anatomical and physiological considerations, specific nursing considerations, and instruments required for basic operations in the field. This is followed by a concise description of operations with a description of the position of the patient, special instruments, and techniques employed. Illustrations of instruments, as well as anatomical drawings of the operations commonly carried out, are depicted. The operations in the surgical specialties are well presented. Each chapter concludes with a number of carefully selected and pertinent references.

The preface states that the book is designed primarily for professional operating room nurses, and it should be of great inter-

est to all who are involved in operating rooms, including both professional and administrative aspects. This text should be an interesting and profitable reference to physicians as well as nurses. Residents in training would do well to review the chapters on cause and prevention of infections and skin cleansing and disinfection.

John M. Beal, M.D.

ENDOGENOUS FACTORS INFLUENCING HOST-TUMOR BALANCE. Edited by Robert W. Wissler, Thomas L. Dao, and Sumner Wood, Jr. The University of Chicago Press, Chicago and London, 1967. 352 pages, \$12.50.

This book is based on a symposium sponsored by the Atomic Energy Commission, Argonne Cancer Research Hospital of the University of Chicago and dedicated to Charles B. Huggins, M.D., a recent Nobel Prize winner, for his work in the field of hormonal control of tumor growth.

It is divided into the following parts:

1. Endocrine Factors in Host-Tumor Relationships
2. Endocrine Changes in the Tumor-Bearing Hosts
3. Modification of Cancer Growth by Humoral and Cellular Mechanisms
4. Factors that Modify the Intravascular and Interstitial Behavior

The volume indeed "brings together for the first time up-to-date knowledge of the ways in which the body can resist the growth and spread of cancer cells." In addition, many gaps in our knowledge about cancer are revealed. The book should be of interest to the experimental pathologist and those interested in cancer research.

Paul B. Putong, M.D.

Female Genital Malignancy

BY MICHAEL S. FARMANS, M.D./CHICAGO

Approximately 80 new patients with malignancy of the female genital tract are seen annually at research and educational hospitals. For the past seven years, it has been possible to follow 95.2 per cent of them after treatment. Our experiences with the type of patient, mechanics of organization, methods of treatment, and results for the years 1958, 1959, 1960 are deemed of sufficient interest for presentation.

PATIENTS

Five hundred and forty-seven patients with invasive cancer of the female genitalia, and 121 with non-invasive cervical dysplasia constitute the basis of this report. They were indigent, and about half non-white. Most lived in Chicago; some came from all parts of the State. A number of patients were received from various state institutions, some mental, provided they could be housed on an open ward. The majority were treated entirely at research and educational hospitals. Patients treated initially elsewhere were accepted only under exceptional circumstances.

Distribution

Table I gives the numbers and percentage distribution of the 547 cancer patients among the various types of invasive cancer. In general, this is similar to the findings of others. The notable exception was vulvar cancer, our relative incidence (5.2 per cent) being almost twice that of others.

All of the 42 patients classified "site unknown" were admitted with advanced abdominal carcinomatosis. Celiotomy was performed and biopsy made in each instance.

MECHANICS OF ORGANIZATION

These patients were presented at a weekly Tumor Conference where jointly the Departments of Obstetrics and Gynecology, Radiology and Pathology reviewed the history, projected the histologic picture on the screen, examined the patient and recommended treatment. The International

Classification was used for cervical cancer and staging was not subsequently changed. For the sake of completeness, patients with International Stage O of the cervix were also presented to the conference. Patients with pelvic mass but no obvious external malignancy were explored operatively before presentation. After treatment the patient was followed in the Tumor Clinic.

During the first year after treatment all patients except those with carcinoma-in-situ were seen on an average of once a month, but each patient was individualized regarding the frequency of visits. During the second year, she was seen bi-monthly. When the patient was free of disease with no gynecologic complaint for two years, she was seen quarterly. After 5 years without disease or symptoms, she was seen annually. A Papanicolaou smear was made at each visit from patients with cervical cancer beginning several months post-radiation. In addition, a punch biopsy of the cervix was taken no later than six months after completion of irradiation.

Table I

FEMALE GENITAL CANCER
(Relative Incidence)

	No. of Patients	Per cent
Cervix	283	51.0
Endometrium	82	15.2
Ovary	75	13.8
Vulva	28	5.2
Vagina	9	1.8
Miscellaneous	28	5.2
Site Unknown	42	7.8
TOTAL	547	100

In addition there were 121 patients with non-invasive cervical dysplasia (Stage O). Includes 3 choriocarcinomas, 7 fallopian tube carcinomas, and 18 corpus malignancies (13 sarcoma and 5 mixed endometrial malignancies).

CERVICAL CANCER

Invasive

From Table II it will be seen that the majority of patients were in Stage III when first seen.

In general, treatment of cervical carcino-

Dr. Farmans is from the Department of Obstetrics and Gynecology, University of Illinois Medical School.

Table II
INVASIVE CERVICAL CANCER
 Stage at Admission
 Compared with World Percentages
 Patients

Stage	Number	Relative per cent	World percentages*
I	42	14.8	24.2
II	80	28.1	38.8
III	151	53.5	30.8
IV	10	3.6	6.8

*From Annual Report on the Results of Treatment in Carcinoma of the Uterus, Vol. 12.

ma was by irradiation. Two sequential radium insertions were done as soon as cervical infection was sufficiently cleared by local treatment. External irradiation was usually by orthovoltage, although the Beta-tron was employed in selected patients.

Thirteen of the 42 Stage I patients received the Wertheim operation as the sole initial treatment. Of these, 11 (84 per cent) are alive and well, although this figure is misleading, because many of the operations were performed recently. Selection of patients for operation depended upon: relative youth, thinness, not too many previous pregnancies.

Results

Only patients treated during the years 1958, 1959 and 1960 are available for five year survival figures, which are shown in Table III. In other words, 10 patients with invasive cervical cancer survived five years, out of every 23 appearing for treatment.

Table III
CERVICAL CARCINOMA
 Five Year Survival
 (Treated in 1958, 1959, 1960)

Stage	Patients number	Alive and Well number	per cent
I	20	15	75
II	35	21	60
III	71	22	31
IV	8	0	0
Overall	134	58	43

(1 patient out of 2.3 survived.)

It was impossible, with the methods at our disposal, to trace 15 of the 283 women with invasive cervical carcinoma. The remaining 268 (94.6 per cent) were available

for the purposes of this report. At the periodic "follow-up" examinations difficulty was experienced with differentiation between fibrosis and tumor infiltration of the pelvic cellular tissues. A most helpful sign in this regard is *pain* and more specifically the *type of pain*. No pain indicates a good prognosis and the induration felt is probably radiation fibrosis. Pain especially in the legs or radiating from back to buttocks, thighs and legs suggests a bad prognosis. Pain in the lower abdomen, suprapubic area or groin is not as meaningful and is seldom a symptom of recurrence. Unilateral lymphedema of extremities almost invariably indicates retroperitoneal metastasis. This is a very late symptom.

Non-Invasive Stage

There were 121 patients with carcinoma-in-situ, averaging 37 years in age. Most of them were discovered in our own clinic where every obstetric and gynecologic patient receives a Papanicolaou smear. In addition all hospital departments generously employ the "Pap" smear. Each of these 121 patients received a tissue biopsy which was a small cone involving 360 degrees of the squamocolumnar junction. Treatment of either carcinoma-in-situ or invasive cervical cancer was always predicated upon tissue biopsy; the smear was never used as the only basis for therapy. Treatment of Stage 0 patients usually was vaginal, sometimes abdominal total hysterectomy. In one patient of the total series of 121, a small microscopic invasion was found by the pathologist when the removed uterus was studied. She was treated postoperatively with deep x-ray and is alive and well.

Of the 121 women, 115 are alive and well, three died of causes other than cancer and three could not be traced.

ENDOMETRIAL CANCER

Eighty-two women with endometrial cancer were seen during the seven-year period of the study. Each patient received uterine curettage so the diagnosis was based on tissue histology. Whenever possible, the diagnostic curettage was combined with intracavitary radium implantation, in order to minimize anesthesia.

Treatment routinely included total hysterectomy and bilateral salpingo-oophorectomy approximately six weeks after radium application. Only a few poor risk patients

were not operated upon. In general, operation was not withheld on the sole basis of advanced age.

Of the 82 women, 68 are alive and well, but many of these were recently treated. All of them have returned for progress examination. Of the 36 patients treated more than five years ago (1958, 1959, 1960) 25, or 69.4 per cent, are alive and well.

OVARIAN CANCER

There were 75 patients with proved (tissue biopsy) ovarian cancer. All patients with suspected ovarian malignancy were submitted to exploration. The rare patient with apparently hopeless cancer but who does not have it, justifies this policy. Without exploration she would be doomed.

Treatment was bilateral salpingo-oophorectomy and total abdominal hysterectomy, whenever it was feasible. With obvious incurability at exploration, a lesser operation, or biopsy only was done. Preoperative irradiation was not employed. Postoperative x-ray was not used routinely. When it was used it was usually directed at some specific area in order to relieve a specific symptom. Installation of radioactive gold, or chromic phosphate was employed for two extremes: 1) to destroy those free wandering, microscopic, cancer cells in those patients where all carcinoma grossly was removed; 2) to reduce production of ascites in near terminal patients.

Forty-five of the 75 patients are alive, but many of these were recently treated. Of the 37 patients treated during the years 1958, 1959, 1960, 19 are alive and well (51 per cent).

CANCER OF VULVA

Twenty-eight patients (3 percent) were seen during the seven-year period. Treatment generally was operative unless there were distant metastases, the patient refuses or there was severe debilitating disease. This was extensive vulvectomy and bilateral groin dissection, including superficial, supra-inguinal nodes, deep nodes along the external iliac to the bifurcation if possible, and the nodes of the femoral triangle. This operation was usually done in two stages: vulvectomy, groins after 2 weeks. Recently, it is being done at one sitting because this is well tolerated and minimizes the considerable morale problem.

Of the 28 patients, 17 are alive and well.

Of the 16 patients treated more than five years ago, eight are alive and well (50 per cent).

PRIMARY VAGINAL CANCER

There were nine patients of whom six were treated by irradiation. Three anterior exenterations, one each in 1962, 1963, 1964 were done on selected patients. The 1962 and 1964 patients are alive and well. The 1963 patient with melanoma has massive recurrence.

SUMMARY

Five hundred and forty-seven patients with invasive malignancy of the female genitalia and 121 with carcinoma-in-situ of the cervix were treated during the seven years between, and including 1958 and 1964. Five year survival has been calculated only for 1958, 1959, and 1960. Distribution of patients among the various types of malignancy conformed to usual experience, except vulvar cancer which was almost twice as frequent as usual.

More than half of the patients with invasive cervical cancer were International Stage III when first seen. Pain is believed to be an important diagnostic and prognostic aid in cancer follow-up.

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Wholesale prescription drug prices have declined 14 percent during the past seventeen years while the wholesale prices of all commodities measured by the U.S. Bureau of Labor Statistics have risen 31 percent.

* * *

While medical costs as a whole are rising, prescription drug price levels are declining and taking less of the consumer's health care dollar than ever before, according to the Pharmaceutical Manufacturers Association.

The Incidence of Lipodystrophy In Juvenile Diabetics

BY HOWARD S. TRAISMAN, M.D., AND LARRY G. MCLAIN, M.D.,/CHICAGO

Lipodystrophy in juvenile diabetes mellitus is a common and unpleasant complication of the disease. The reported incidence of insulin induced atrophy and hypertrophy varies from 24-44 percent¹⁻⁵. We are reporting our findings in 238 children with diabetes mellitus.

Methods

The patients for this study were 238 diabetic children, 119 girls and 119 boys, ranging in age from one to 19 years. The patients were followed in the out-patient department of Children's Memorial Hospital, Chicago, as private patients of one of us (HST), or were seen at the Diabetes Camp sponsored by the Diabetes Association of Greater Chicago in the summer of 1966.

After a review of the histories and the records, the diabetic children were divided into three groups based upon their degree of control: good, fair or poor. The standards for these criteria of control have been reported elsewhere⁶.

Each child was given a complete physical examination and specific attention was paid to the presence or absence of insulin atrophy or hypertrophy. The type and dosage of insulin used by each patient was also recorded.

Results

The distribution of the 238 children in the study according to their age and sex at the time of the examination is shown in Table 1; 64 percent of the patients were between eight and 14 years of age.

Of the 238 patients, 161 of them (68

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Larry G. McLain, M.D., is a resident in Pediatrics at the University of Colorado. He is a graduate of the University of Illinois College of Medicine and served his internship at Children's Memorial Hospital, Chicago.

Table 1.

Age (years)	Male	Female	No. Without Atrophy	No. With Atrophy	No. Without Tumors	No. With Tumors
0	0	0	0	0	0	0
1	1	0	1	0	1	0
2	1	2	3	0	3	0
3	1	3	2	2	3	1
4	1	2	3	0	3	0
5	3	7	4	6	7	3
6	3	2	1	4	2	3
7	7	3	5	5	7	3
8	12	5	7	10	13	4
9	13	10	15	8	16	7
10	16	11	18	9	19	8
11	12	14	16	10	19	7
12	18	19	24	13	30	7
13	10	12	16	6	20	2
14	4	8	9	3	9	3
15	5	7	9	3	9	3
16	4	5	4	5	3	6
17	4	6	8	2	9	1
18	2	2	2	2	3	1
19	2	1	3	0	3	0
119	119	150	88	179	59	

percent) have had their diabetes less than five years as shown in Table 2.

A total of 88 children (37 percent) had evidence of atrophy on either legs, arms or buttocks. Of this group there were 34 boys (14.4 percent of the total group) and 54

Table 2.

Duration of Diabetes Yrs.	No. of Children
0	13
1	41
2	33
3	38
4	36
5	20
6	20
7	14
8	10
9	7
10	2
11	2
12	1

Table 3.

Interval After Onset of Diabetes Years	Incidence of Atrophy	Incidence of Tumors
0	11	10
1	38	17
2	17	15
3	12	4
4	4	4
5	1	5
6	4	3
7	1	1
8	0	0

girls (22.7 percent of the total group). The difference in sex was found to be statistically significant ($p=.034$).

The number of children with atrophy in each group is shown in Table 1.

Seventy-eight of the 88 children (86 percent) were noted to have the onset of atrophy within 48 months after the diagnosis was made. (Table 3).

The mean time for the onset of atrophy after the diagnosis was made was 24 months. For boys, however, it was 28 months and 22 months for girls. This was not statistically significant.

The most common location for insulin atrophy was on the legs (72 out of 88-82 percent), next the arms (44 of 88-50 percent), and then the buttocks (16 of 88-18 percent). Several children exhibited atrophy in more than one area. (Table 4).

Fifty-nine children (25 percent of the total group) had evidence of hypertrophy on either arms, legs or buttocks. Of this group, there were 24 girls (10.1 percent) and 35 boys (14.7 percent). This did not prove to be statistically significant.

Table 1 shows the number of children with hypertrophy in each age group.

Table 3 shows the number of children with hypertrophy and the interval after the onset of their diabetes. Forty-two of the 59 children (71 percent) were noted to have the onset of hypertrophy within 36 months after the diagnosis of diabetes mellitus was made.

The mean time for the onset of hypertrophy after the diagnosis was made was 28 months. For boys, it was 24 months and for girls it was 31 months. This was not found to be statistically significant.

The most common location for hypertrophy was the legs (42 of 59-71 percent), then the arms (23 of 59-39 percent) and

last the buttocks (9 of 59-15 percent). Several children exhibited hypertrophy in more than one area. (Table 4.)

As shown above, 88 children (37 percent) exhibited signs of atrophy and 59 children (25 percent) showed signs of hypertrophy. This difference was found to be statistically significant ($p=0.017$) (Table 4).

Table 4.

Children With Atrophy		
Total—88		
Legs	72	82%
Arms	44	50%
Buttocks	16	18%
Children With Tumors		
Total—59		
Legs	42	71%
Arms	23	39%
Buttocks	9	15%

Table 5 shows that there were 128 children in good control, 42 of whom had insulin atrophy, and 27 had insulin hypertrophy, or a 55 percent incidence of lipodystrophy. Of those in fair control, 41 had atrophy, and 22 had hypertrophy or a 70 percent incidence of lipodystrophy. Of those in poor control, five had atrophy and 10 had hypertrophy, or a 71 percent incidence of lipodystrophy. Although children who are maintained in good control appear to have a lowered incidence of atrophy and hypertrophy than those in fair or poor control, no statistical difference could be demonstrated.

Table 5.

Control	No.	%
Good	128	
Atrophy	42	
Tumors	27	
Total	69	55%
Fair	89	
Atrophy	41	
Tumors	22	
Total	63	70%
Poor	21	
Atrophy	5	
Tumors	10	
Total	15	71%

There were 30 children (12.1 percent) who had both atrophy and hypertrophy, 16 boys and 14 girls. Of these 30 children, 11 were in good control, 15 were in fair

control and four were in poor control.

All of the 238 children received at least one injection of insulin per day. None were receiving oral agents alone although one child at Diabetes Camp received tolbutamide in conjunction with PZI insulin; 128 of the children received more than one type of insulin, usually crystalline insulin in combination with Lente or NPH insulin. Fifty-six were receiving Lente insulin, 49 NPH insulin and five PZI insulin. The mean daily dose of insulin was 29 units.

Discussion

Insulin induced atrophy and hypertrophy are most frequently seen in the adult female diabetic and juvenile diabetics of both sexes.^{1-5,7,8} Joslin and associates¹ reported 24.2 percent atrophy in diabetics of all ages with an incidence of 44.4 percent in those individuals under 20 years of age as opposed to 14.9 percent in those individuals over 20 years of age. Under 20 years of age, insulin atrophy is more common in females than in males, 49.1 percent-39.6 percent. Over 20 years of age, insulin atrophy occurs seven times as frequently in females as in males with diabetes. Insulin hypertrophy was found in 39.3 percent of males and 17.9 percent of females under 20 years of age, and 20.5 percent and 11.5 percent respectively in diabetics over 20 years of age. Danowski's² findings compare with those of Joslin. Twenty-eight-40 percent incidence of insulin atrophy has been reported by others.^{3,4} Sterky⁵ also found a higher incidence of insulin atrophy in juvenile female diabetics (26.4 percent) than in males (9.1 percent). Insulin hypertrophy occurred in 16.7 percent of the females and 9.1 percent of the males; 4.5 percent of the boys and 6.9 percent of the girls had a combination of atrophy and hypertrophy. The combination of atrophy and hypertrophy existing in one individual is common.

Histologically, insulin atrophy results from a disappearance of fat from the tissues involved. Insulin atrophy is usually seen in the areas of injection such as the arms, thighs or buttocks. However, atrophy may also be found in areas distant to the sites of injection.

The histologic findings of insulin induced hypertrophy are those of an enlarged fat cell with increased total fat. These soft swellings occur at the usual sites of injection.

They may become so large as to interfere with the proper fit of clothes.

There is no proven etiology for the diabetic lipodystrophies. Trauma, allergy, infection, temperature, type, impurities and pH of insulin, and technique of injection of insulin have been mentioned as possible causes.

Treatment consists of rotation of injection sites and intramuscular rather than subcutaneous injections (the absorption rate of insulin is the same). In the past we have also advocated the use of pure beef or pork insulin, and keeping the insulin at room temperature.⁹ At present we have not found any beneficial effect from the last two recommendations. One author has recommended subcutaneous injections of coconut oil to reduce insulin atrophy.¹⁰

Diabetic lipodystrophies induced by insulin are benign conditions but cosmetically and emotionally disturbing.^{7,11} Parents and patients must be reassured that the prognosis for recovery is excellent, but that it may take years to accomplish.¹² The occurrence of insulin atrophy or hypertrophy in girls (22.7 percent) and hypertrophy is never severe enough to abandon the use of insulin¹³ especially in growth onset diabetics.

Summary

A total of 238 diabetic children, 119 boys and 119 girls, from age one-19 were examined for evidence of lipodystrophy. Eighty-eight children (37 percent) had atrophy, 59 children (25 percent) had hypertrophy. Atrophy was more prominent in girls (22.7 percent) and hypertrophy was more prominent in boys (14.4 percent).

The authors wish to express their appreciation to Mrs. Lorraine Borman at the Northwestern University Computing Center for programming this data, and to Dr. Henry Nadler for his review and statistical analysis of the data.

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ISMS Malpractice Insurance Now In Effect

Open to All Specialties, All Ages

By DON B. FREEMAN, DIVISION OF PUBLIC RELATIONS AND ECONOMICS

A new malpractice insurance program—sponsored by Illinois State Medical Society and approved by the State of Illinois Insurance Department—became available to ISMS members on June 1. Members may enroll in it at any time.

Administering the plan is Parker, Aleshire & Company, Skokie, Ill., which has served the Society since 1946. The underwriter is the Employers' Group of Insurance Companies, 82-year-old Boston firm.

ISMS thus becomes the seventh state medical society to launch its own professional-liability program. What compelled ISMS to take this step? What benefits and protections does the program provide? What about its premium rates? What must members do to help keep the program strong?

The ISMS Public Relations and Economics Division put these and similar questions to Dr. Frederick Z. White. He is chairman of the Medical Economics & Insurance Committee, which explored the professional-liability problem and ushered in the program.

What made ISMS decide it should sponsor a professional-liability program?

Physicians around the state wrote and telephoned us for help in getting malpractice policies. Many complained that their coverage had been abruptly cancelled, usually because they practiced in a high-risk specialty or had reached age 65. Others told of stiff increases in their premium rates, or of shifts to a higher-rate category. Also, physicians wanted adequate protection against the growing legal hazards—and they didn't feel they were getting it.

Just what are some of these legal hazards, Dr. White?

Insurance companies have tended to settle malpractice suits rather than build a defense against them. Such settlements amount to an admission of guilt and can hurt the physician's practice. Also, they encourage nuisance suits—as do various recent actions of the courts and General Assembly. For example, the assembly last year removed the \$30,000 limit on the amount recoverable for negligently causing a death...and the courts relaxed an "expert testimony" requirement in malpractice trials.

How will the ISMS program build stability and security?

ISMS will directly supervise and control the program, in conjunction with the administrator and underwriter. Coverage will be available regardless of age or type of specialty. No policy will be cancelled, nor



Dr. Frederick Z. White

application declined, without just cause and a review by an ISMS designee. Any requests for premium-rate increases will be submitted to the Medical Economics Committee for review and approval. The underwriter will expend every effort to improve the legal climate.

Just how will the legal climate be improved?

In several important ways. No claims will be settled without the written approv-

al of the insured member. The underwriter will retain outstanding defense counsels. . . notify the legal profession that every nuisance claim will be fought with vigor. . . tell ISMS members how to prevent claims, and keep them posted on legal developments in the malpractice field. ISMS, in turn, will provide expert medical testimony and advice to help the insurer mount a sound defense against any claims. And the Society will assist in the job of education.

What kind of coverage does the program afford?

Coverage from \$5,000 to \$1,000,000 is

available. Most physicians probably will want policies ranging from the \$50,000 each claim/\$150,000 aggregate claims category to the \$100,000/\$300,000 category. The policies include coverage for the physician to the extent he is legally liable for negligent acts of employees. In a word, the protection compares favorably with that offered by other insurers. And as I said, it is available to *all* specialties, *all* ages.

What about the premium rates, Dr. White?

They are in line with the rates required by companies already providing this kind

(Continued on page 760)

**HYPOTHETICAL EXAMPLES OF PREMIUMS
ISMS PROFESSIONAL LIABILITY PROGRAM**

No deviations from these examples may be made. It is important to remember that each case will be rated on the basis of information submitted to the insurance company on the application form, and any additional information obtained by them.

Territory I Cook, Lake, Peoria, Madison, St. Clair Counties.

Territory II All other counties in Illinois.

	Limits	Territory I	Territory II
<i>Physician—No Surgery</i>			
Such as—Dermatologists	15/45	\$ 64.00	\$ 60.00
Internists	50/150	77.00	74.00
Pathologists	100/300	84.00	80.00
<i>Physician—No Surgery</i>			
Same as above including:	15/45	100.00	96.00
1 Employed Physician	50/150	121.00	118.00
1 X-ray technician	100/300	132.00	128.00
<i>Surgeon—Performs or assists in</i>	15/45	178.00	171.00
Major Surgery on OTHER THAN	50/150	217.00	208.00
OWN PATIENT	100/300	237.00	227.00
(Cardiac surgery not included)			
<i>Surgeon—Same as above plus:</i>	15/45	244.00	237.00
1 Employed Surgeon	50/150	298.00	289.00
1 Employed X-ray technician	100/300	325.00	315.00
<i>Surgeon—Performs Major Surgery</i>	15/45	\$384.00	\$287.00
ON OWN PATIENTS	50/150	469.00	350.00
including Cardiovascular Surgery	100/300	511.00	381.00
<i>Surgeon—Same as above plus:</i>	15/45	464.00	367.00
1 Employed Surgeon	50/150	568.00	449.00
1 Employed X-ray technician	100/300	618.00	488.00
<i>Special Class—Anesthesiologist</i>			
Obstetrician	15/45	543.00	338.00
Gynecologist	50/150	662.00	412.00
Orthopedist	100/300	721.00	449.00
Neurosurgeon			
Plastic Surgeon			
<i>Special Class—Same as above plus:</i>	15/45	579.00	374.00
1 Employed Physician—No Surgery	50/150	705.00	456.00
1 Employed X-ray technician	100/300	769.00	497.00

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Premium rates up Aug. 1 for ISMS Major Medical Plan

Increased premium rates under the ISMS-sponsored Group Major Medical Program will take effect Aug. 1. A dangerously high ratio of payments to premiums prompted the ISMS Board of Trustees to approve this increase—first in the insurance program's 2½ years. While the loss ratio was 50.5% in the year beginning Aug. 1, 1965, it soared to 93.4% the following year and 84% in the six months beginning last Aug. 1, according to Parker, Aleshire & Co., administrator. "The indemnities leave too small a margin of funds for expenses, contingencies and reserve," said Dr. Frederick Z. White, chairman of the ISMS Medical Economics & Insurance Committee. Premium hikes will depend on age and number of dependents. In the 40-49 age bracket, for example, the semi-annual increases under the \$500 deductible plan will be \$4.75 for a member, \$12.50 for a member and two dependents; under the \$1,000 plan, these will be \$2.70 and \$7.60. Enrollment in the program has almost doubled in the 2½ years of its existence.

IDPA Payments to Physicians \$10,654,- 013 in 15 Months

The Illinois Department of Public Aid paid physicians \$10,654,013 through March, 1968, for services rendered after Jan. 1, 1967—starting date of the IDPA usual and customary fee payment policy. Cook County physicians received \$5,558,196, with downstate physicians receiving \$4,983,185, and out-of-state MD's \$112,632. Trailing Cook County in payments were St. Clair County physicians, \$1,026,746; Peoria County, \$269,039; Madison, \$196,122; Sangamon, \$192,286; Macon, \$189,110; Winnebago, \$178,895; Adams, \$154,396; Williamson, \$143,548; Champaign, \$142,146; Saline, \$108,001; Jefferson, \$107,574, and Jackson, \$105,349.

73% Additional Phy- sicians Billing IDPA Since Mid-1967

The number of physicians treating Public Aid recipients has risen from 3,228 in June, 1967, to 5,554 last March. Broken down, the Cook County increase was from 740 to 1,795; downstate from 2,376 to 3,195, and out-of-state from 112 to 564. Second to Cook County as of March was Winnebago County, with 199 participating physicians. Others with at least 100 physicians were Champaign, DuPage, Kane, Macon, Peoria, Rock Island, Sangamon, St. Clair and Will. The count excluded physicians billing only for Medicare.

IDPA Says In-Patient Care Far Over Estimate

IDPA payments for in-patient hospital care are likely to hit \$90,000,000 for the two years ending June 30, 1969, exceeding the estimate by \$33,000,000, Director Harold O. Swank told the ISMS Committee on Usual and Customary Fees.

+++++

Establish Local Authority, Winnebago Man Urges IDPA

"IDPA should assign 'sophisticated, responsible' personnel to larger towns to handle inquiries and complaints about fees and related problems," said Don Westbrook, executive administrator of the Winnebago County Medical Society. Centralization in Springfield has caused a basic problem in communications, he contended. Westbrook made his suggestion to IDPA officials at a meeting of the ISMS Committee on Usual and Customary fees.

+++++

95% of Eligible Oldersters Taking Medicare Insurance

About 18½ million older Americans—95% of the eligible total—were enrolled for the medical-insurance part of Medicare as of April 1, when the open-enrollment period ended, the Department of Health, Education and Welfare reported. Of the 17,800,000 persons signed up at the start of the enrollment period, only 38,000 have given notice of a wish to terminate, the report added.

+++++

M. D. Reaction Cautious on Report of "Hunger Counties"

Southern Illinois physicians have been discussing a Washington, D.C., citizens' committee report that lists Alexander and Pulaski among 256 "hunger counties" in the U.S. Dr. Willard C. Scrivner, East St. Louis, ISMS 10th district trustee, said, "The medical profession invites the opportunity to participate in a proper and true evaluation of the situation with properly authorized people before commenting on it." The report was issued by the private Board of Inquiry into Hunger and Malnutrition.

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ISMS Committee to Weigh LSD, Marijuana Law Changes

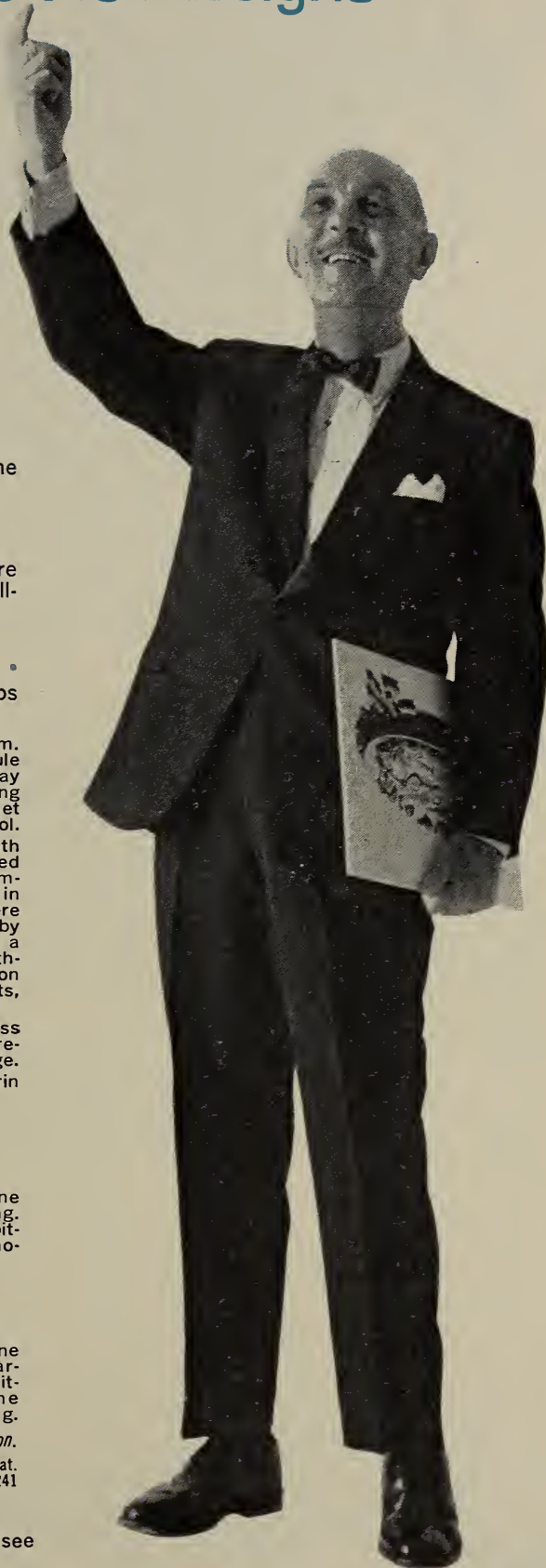
The ISMS Committee on Narcotics and Hazardous Substances this month will discuss possible changes in state laws on LSD and marijuana, including penalties for possession, said Dr. Joseph H. Skom, chairman. "It is fully recognized that these are dangerous drugs, and that controls are necessary, but the structure of the law should carry out the intent of the law," he said. In April the committee sponsored a national symposium on psychedelic drugs and marijuana in Chicago.

—By DON B. FREEMAN

DECLINING YEARS

By the way, I agree with the lusty octogenarian lady debater who protested against a fixed drawing up of age groups. I suggest that a young man is one whom a pretty girl can make happy or unhappy; a middle-aged man is one whom a pretty girl can make happy but no longer unhappy; and an old man is one whom a girl can no longer make either happy or unhappy. With women, it is quite otherwise. A woman's declining years are under 25: she rarely declines after. (Sanctity of Life. Prof. David Daube. Proc. Roy. Soc. Med. Symposium No. 9. The Cost of Life. 60:11-Pt. 2 (Nov.) 1967.)

"This way please,
to help your overweights
change their 'weighs'"



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based on examination and evaluation of the patient's overweight condition.

OBEDRIN®-LA . . .

as part of your prescribed regimen, where indicated. "Trickle-releases" medication for all-day appetite control.

OBEDRIN MENU PLAN . . .

provides adequate protein intake and helps 'overweights' establish better eating habits.

DOSAGE: Obedrin-LA—1 daily, usually at 10 a.m. Obedrin Tablets and Capsules—1 tablet or capsule at 10 a.m. and 3 p.m. A third tablet or capsule may be given in the evening to discourage late evening snacks. Obedrin tablets are grooved so a half-tablet can be taken if it is found sufficient for appetite control.

CAUTION: Should not be given concurrently with monoamine oxidase inhibitors. It should be used with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates, and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such cases, withdrawal of medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

SIDE EFFECTS: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage.

SUPPLY: Obedrin-LA—Bottles of 50 and 250. Obedrin Tablets and Capsules—Bottles of 100 and 1000.

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Each two-layer tablet contains: Methamphetamine Hydrochloride*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit-forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg.

Obedrin®

Tablets—Capsules

Each tablet or capsule contains Methamphetamine Hydrochloride, 5 mg.; Pentobarbital, 20 mg. (Barbituric Acid derivative; Warning: May be habit-forming); Ascorbic Acid, 100 mg.; Thiamine Mononitrate, 0.5 mg.; Riboflavin, 1 mg.; Niacin, 5 mg.

CAUTION: Federal law prohibits dispensing without a prescription.

*U.S. Patent Nos. 2,736,682; 2,809,917; 2,809,916; 2,809,918 and pat. pend. **U.S. Patent Nos. 2,648,609; 2,799,241

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ILLINOIS ASSOCIATION OF THE PROFESSIONS

With this issue of The Illinois Medical Journal, we introduce a regular feature on the Illinois Association of the Professions to keep you abreast of the professional activities of your associates from the other professions. We hope you will find this feature informative and will recognize the need for an Association to represent the professions—as labor and business have already discovered. Organizational members of the IAP and their professional abbreviations are:

Illinois Council, American Institute of
ArchitectsA.I.A.
Illinois Society of Certified Public
AccountantsC.P.A.
Illinois State Dental SocietyD.D.S.
Illinois Society of Professional EngineersP.E.
Illinois State Bar AssociationLL.B. or J.D.
Illinois State Medical SocietyM.D.
Illinois Pharmaceutical AssociationR.Ph.
Illinois State Veterinary Medical
AssociationD.V.M.

Individual memberships in IAP are also available for those who are already members in good standing of their state professional societies.

Your support is encouraged.



Officers of IAP for 1968

Seated (from left) R. Neal Fulk C.P.A., Secretary-Treasurer; Phillip J. Kartheiser, D.D.S., President; Franklin Lee, R.Ph., President Elect; standing; Vice Presidents: Walter D. Linzing, P.E.; Walter H. Sobel, A.I.A.; Eugene L. Vickery, M.D.; Stanton Ehrlich, LL.B. Missing from the photo is Ronald J. Kolar, D.V.M.

(Continued on page 764)

IAP MEMBERSHIP APPLICATION FORM

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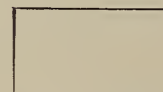
TOWN

SIGNATURE

DATE

I certify that this applicant for IAP membership is a member in good standing of our state professional association.

Please return this application form to the executive office of **your professional society**, along with your check for \$10 payable to the ILLINOIS ASSOCIATION OF THE PROFESSIONS.



Ex. Dir. Initials

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

Contraindications: History of hypersensitivity to any component.

Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.

Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic

fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.

Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.



350-B

Clinics for Crippled Children

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 2, Quincy—St. Mary's Hospital
 July 3, Hinsdale—Hinsdale Sanitarium
 July 9, East St. Louis—Christian Welfare
 July 9, Peoria General—Children's Hospital
 July 10, Champaign-Urbana—McKinley Hospital
 July 10, Joliet—St. Joseph's Hospital
 July 11, Sterling—Community General Hospital
 July 11, Flora—Clay County Hospital
 July 11, Cairo—Public Health Building

July 11, Springfield General—St. John's Hospital
 July 11, Peoria Cerebral Palsy (A.M.)—Zeller Zone Center
 July 12, Chicago Heights Cardiac—St. James Hospital
 July 17, Evergreen Park—Little Company of Mary Hospital
 July 18, Decatur—Decatur & Macon Co. Hospital
 July 18, Elmhurst Cardiac—Memorial Hospital of DuPage County
 July 23, Danville—Lake View Hospital
 July 23, East St. Louis—Christian Welfare Hospital
 July 23, Peoria General—Children's Hospital
 July 24, Rockford—St. Anthony's Hospital
 July 24, Centralia—St. Mary's Hospital
 July 24, Springfield Cerebral Palsy (P.M.)—Diocesan Center
 July 24, Elgin—Sherman Hospital
 July 24, Mt. Vernon—Good Samaritan Hospital
 July 25, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
 July 26, Chicago Heights Cardiac—St. James Hospital

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed 12 to 16 manuscript pages, (including illustrations) and should be briefer if possible.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
 Illinois Medical Journal
 360 N. Michigan Ave.
 Chicago, Ill. 60601.

The AMBAR
SCRAPBOOK
of

Obesity Oddities

FACT & LEGEND

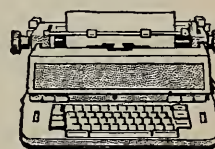


SPARTAN YOUNG MEN

LINED UP NAKED
EVERY MONTH FOR INSPECTION
TO DETECT CORPULENCY.

THE SPARTANS WERE SO CONCERNED
WITH GOOD PHYSIQUE THAT FAT
CITIZENS WERE ASSIGNED
SPECIAL EXERCISES!

YOUR SECRETARY WILL BURN UP
90 FEWER CALORIES PER DAY, IF
SHE SWITCHES FROM A MANUAL TO
AN ELECTRIC TYPEWRITER.



DIETING IS GREATEST IN THE MONTHS:
JANUARY-FEBRUARY AND MAY-JUNE.

OVERWEIGHT PEOPLE
ARE LEAST
INTERESTED
IN DIET IN DECEMBER.



THE Cost of
AMBAR EXTENTABS

IS APPROXIMATELY
ONE-HALF THAT OF
OTHER LEADING
APPETITE
SUPPRESSANTS.



AN IMPORTANT FACTOR
IN LONG-TERM THERAPY!

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting. Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H ROBINS

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

CARROLL COUNTY: Savanna; population: 5200. Trade area: 20,000. 3 physicians in same group. 1 physician died recently. Savanna City Hospital; 44 beds. 90 miles from Rockford. 2 drug stores. Financial assistance if desired. Predominant nationalities: Irish, Italian and Mexican. Protestant & Catholic churches. Public & parochial schools. Recreational facilities include golf, swimming, boating, fishing and hunting. State park 3 miles. For details contact Martin Lantau, Savanna, M. F. Cipala, Administrator, Savanna City Hospital, Savanna or M. H. Kreimeier, Savanna.

CASS COUNTY: Beardstown; population 6500; trade area: 20,000. 7 doctors. ages 40, 46, 53, 53, 51 and 60. 1 attempting gradual retirement due to health. Schmitt Memorial Hospital; 55 beds; 42 miles from Springfield. 3 prescription drug stores. Numerous office facilities including space in Beardstown Clinic if association desired. Predominant nationalities: German & Irish. Agriculture and small industry. Oscar Meyer plant opened 1967. Employs over 400. 16 Protestant and Catholic Churches. 2 golf courses; boat harbor on Illinois River. Swim pool, good parks, fishing & hunting. For further information

contact T. A. Starkey, M. D., Beardstown. Phone 323-1146.

CASS COUNTY: Virginia; population: 1700. Population of trade area: 3500. Only physician moved in order to specialize, 11-1-1967. Replacement needed. Nearest Doctor 13 miles. Nearest hospital, 13 miles at Beardstown. 33 miles from Springfield. Local prescription store. Office space available. Agricultural community. 7 protestant and catholic churches. Grade & high schools. Local golf course. For detailed information contact: Mr. David B. Finney, 242 S. Stowe St., Virginia. Phone: 217: 452-3784 or 452-7441.

CLARK COUNTY: Westfield. Population: 700. Town without a doctor since 1957. Nearest hospital 10 miles; 22 miles to Paris Hospital, 32 beds. Homes available at reasonable prices. Financial assistance available from local American Legion Post. Nearest city Terre Haute, Ind. Agricultural area, four churches, grade and high schools. Eastern Illinois University 12 miles. Golf and swimming facilities 11 miles. For further information contact Mr. Lonnie Baker, Westfield.

CLARK COUNTY: West Union; population: 650. Trade area: 5,000. Only physician died in 1953. Nearest physicians at Marshall, 13 miles, and Robinson, 18 miles. Nearest hospitals at Robinson and Terre Haute, Ind. Agricultural community. Churches: Baptist, Nazarene, and Christian. Grade school. Active Masonic Lodge. For further information contact:

Mr. Burl Medsker, West Union
Mr. Lyman K. Shaulee, West Union
Mr. Dean Monk, West Union
Dr. E. P. Johnson, Casey.

CLAY COUNTY: Flora; population 5,350. Five physicians. Clay County Hospital located here, board certified surgeon on staff. St. Louis 85 miles. Office space available. Financial assistance could be arranged. Four small factories, two prescription drug stores. Churches: Protestant, Catholic. Swimming pool. Small lake. For details contact L. R. Gerber, Administrator, Clay County Hospital, Flora. Phone 618-662-2131 or 618-662-5946.

IRON DEFICIENCY

ANEMIA



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brothers
in one
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respect...iron



LAKE SIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON[®]
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package Insert for complete prescribing Information.



The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.



WM. P. POYTHRESS & CO., INC.
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Manufacturers of ethical pharmaceuticals since 1856

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

NEW SINGLE CHEMICALS

SULLA Sulfonamide R

Manufacturer: A. H. Robins Co.

Nonproprietary Name: Sulfameter

Indication: Acute and chronic urinary tract infections.

Contraindications: Hypersensitivity to sulfonamide derivatives, including antibacterials, oral hypoglycemics, and thiazides; marked renal or hepatic impairment; not for generalized bacterial infections; not for pregnant women near term or nursing mothers.

Dosage: Patients over 100 lbs. or 12 yrs. of age:

First day—1500 mg., single dose

Maintenance—500 mg., single daily dose

Not for children under 12 years.

Supplied: Tablets—500 mg., bottles of 50 and 500.

TEGRETOL Trigeminal neuralgia R

Manufacturer: Geigy Pharmaceuticals

Nonproprietary Name: Carbamazepine

Indications: Trigeminal neuralgia

Contraindications: Known sensitivity to any of the tricyclic compounds such as amitriptyline, desipramine, imipramine, etc. Use with MAO inhibitors is not recommended.

Dosage: 100 mg. with meals, twice on the first day, gradually increased by 100 mg. q12h until freedom from pain. Maintenance—400 to 800 mg. daily.

Supplied: Tablets—200 mg., bottles of 100 and 1000.

DUPLICATE SINGLE PRODUCTS

HISTASPAN Antihistamine R

Manufacturer: USV Pharmaceutical Corp.

Nonproprietary Name: Chlorpheniramine maleate.

Indications: Symptomatic relief of allergic manifestations in vasomotor rhinitis, hay fever, urticaria, angioneurotic edema, sensitivity reactions, insect bites, other itching skin conditions including pruritus ani, pruritus vulvae, pruritus of drug rash, atopic dermatitis and contact dermatitis.

Contraindications: Known hypersensitivity to the drug.

Dosage: One capsule q12h.

Not for children under 12 yrs.

Supplied: Capsules, sustained release—8 and 12 mg., bottles of 100.

MANDACON Antiinfective—Urinary R

Manufacturer: Conal Pharmaceuticals

(Continued on page 756)

Is it depression?

She says "I'm always on edge..."

**...but her other symptoms:
depressed mood, insomnia,
anorexia, feelings of guilt
strongly suggest
an underlying depression.**

when the diagnosis is depression

ELAVIL[®]HCl

AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

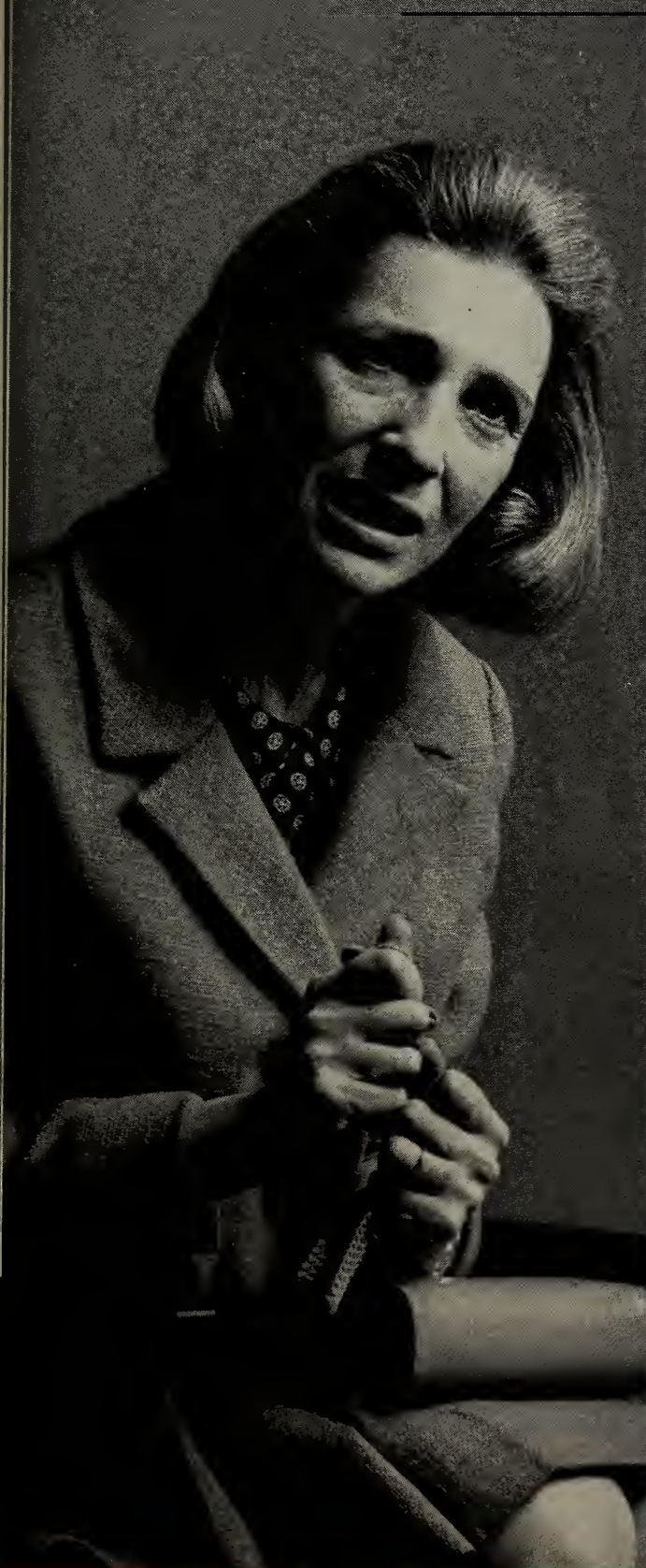
Before prescribing or administering, read product circular with package or available on request.



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The anticostive hematinic is
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Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate).....	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron).....	100 mg
Vitamin B ₁	7.5 mg
Vitamin B ₂	7.5 mg
Vitamin B ₆	7.5 mg
Vitamin B ₁₂	50 mcgm
Vitamin C.....	200 mg
Niacinamide.....	30 mg
Folic Acid.....	0.05 mg
Pantothenic Acid.....	15 mg

Bottles of 60



anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.)
Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)



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New Pharmaceutical Specialities

(Continued from page 754)

Nonproprietary Name: Methenamine mandelate.
Indications: Long-term management of chronic as well as milder subacute urinary tract infections.

Contraindications: Severe renal insufficiency; history of previous hypersensitivity to the drug.

Dosage: Adults—Two tablets qid or less as required, with liberal fluid intake.

Older children—reduce dosage in proportion to age and weight.

Supplied: Tablets—500 mg., bottles of 160.

SORBITRATE Carioc depressant R

Manufacturer: The Stuart Co.

Nonproprietary Name: Isosorbide dinitrate.

Indications: Angina pectoris.

Contraindications: History of hypersensitivity to the drug.

Dosage: 5 to 10 mg. orally or sublingually, 3-4 times daily.

Supplied: Tablets—5 and 10 mg. oral, bottles of 100. 5 mg. sublingual, bottles of 100.

COMBINATION PRODUCTS

FERO-FOLIC-500 Hematinic R

Manufacturer: Abbott Laboratories

Composition: Ferrous Sulfate 525 mg.

Folic Acid 350 mcg.

Ascorbic Acid 500 mg.

Indications: Prevention and treatment of iron and folate deficiency anemias in pregnancy.

Contraindications: None mentioned.

Dosage: One tablet daily.

Supplied: Filmtabs—bottles of 100, 500 and 5,000.

INFLUENZA VIRUS VACCINE, Bivalent R

Biological

Manufacturer: Lederle Laboratories

Composition: Each cc. contains:

A₂ (Japan 170/62) 150 CCA units

A₂ (Taiwan 1/64) 150 CCA units

B (Massachusetts 3/66) 300 CCA units

Indications: Immunization against influenza virus.

Contraindications: Hypersensitivity to eggs or egg products.

Dosage: Primary immunization:

Adults—two doses of 1 cc. each, s.c., at two mos. interval.

Children 3 mos. to 5 yrs.—three doses of 0.1-0.2 cc., s.c., at intervals of 1-2 wks. and 8 wks. respectively.

Children 6 to 10 yrs.—two doses of 0.5 cc. each, s.c., at two months interval.

Booster doses:

Single doses in same range as above.

Supplied: Vials—10 cc.

LIQUIMAT-HC Corticoid—Local R

Manufacturer: Texas Pharmacal Co.

Composition: Sulfur 5%

Hydrocortisone 0.5%

Alcohol 22%

Indications: Acne, acne rosacea, seborrheic dermatitis.

Contraindications: Tuberculous, fungal, and most acute viral diseases of the skin. Not for treatment of cutaneous manifestations of pemphigus or lupus erythematosus. Not for ophthalmic use.

Dosage: Apply to affected area twice daily.

Supplied: Lotion, tinted—plastic bottles of 1.5 oz.

NASOCON Nasal decongestant o-t-c

Manufacturer: Smith, Miller & Patch, Inc.

(Continued on page 768)



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

You won't have to wait for these results to come back from the lab. Because now you can do blood chemistry tests in your own office. With Diagnostest* reagents and instruments. You get accurate, precise results in minutes. And we teach your nurse or medical assistant to do the tests. The system can be used to measure hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. Write today for full details.

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U. S. Public Health Service Team to Survey Chicago Area Children

The Public Health Service's Health Examination Survey, authorized by Congress in 1956, will visit the Chicago area in June to examine a sample of the teen-aged population (ages 12 through 17 years). The survey will be conducted during the period June 27 through Aug. 13. This will be a part of a series of examinations of a nationwide health survey of some 8,000 youngsters.

About 200 youths to be examined will be chosen by a scientific sampling process from the 12-through-17-year old group of the Chicago area (which includes Cook, DuPage, Kane, Lake, McHenry, and Will Counties in Illinois as well as Porter and Lake Counties in Indiana).

The examinations will be given in the Health Survey's mobile examination center, which will be brought to the area the latter part of June and set up at a convenient location.

Purpose of the examinations is to collect on a uniform basis statistical information on various aspects of the health of the youngsters and to obtain data on certain physical and physiological measurements relating to growth and development in this age group.

Physicians, Dentists, Psychologists

The process will include a special examination by a physician of the eyes, ears, nose and throat, heart and neuromuscular systems; a dental examination by a dentist; a test of visual acuity and color vision; recordings of blood pressure; biological and biochemical tests of a blood sample, an audiometric test for hearing performed in a soundproofed room; an X-ray of the hand and wrist for bone age; an X-ray of the chest for cardiovascular and pulmonary abnormalities; a 10-lead electrocardiogram and phonocardiogram of the heart; a timed vital capacity test using a wedge spirometer; an exercise tolerance test under a measured workload using a treadmill; a grip-strength test; recordings of height, weight, and various other measurements of growth and development; and measurements of verbal, perceptual and social skills by a psychologist.

The Health Examination Survey is de-

signed to collect data primarily on the health aspects of growth and development. The survey is not intended as a screening procedure; referral for diagnosis is not made. The fact that the examination is not complete and is not a substitute for a visit to one's own physician and dentist is stressed with the parents of each youth examined. No part of the results of the examination, except for a card stating the blood type, will be disclosed to the youth or his parents. A report of relevant findings will be sent to the youngster's physician and dentist when the parents request that this be done.

Third Cycle Examined

The examining physicians will be senior residents or fellows in pediatrics working temporarily with the Public Health Service. Other members of the examining team will include a nurse, a dentist, two psychologists, and X-ray and other technicians regularly on the PHS staff.

This health examination of youth is referred to as the Third Cycle of the Health Examination Survey. Earlier, a Second Cycle of the children's health examinations (ages 6 through 11) was completed in December, 1965. Over a 30-month period, 7,129 children were examined in 40 locations across the nation. A first cycle of adult health examinations, ending in late 1962, completed a three-year survey and examined a total of 6,672 adults (ages 18 through 79 years).

Unethical to Accept Gifts

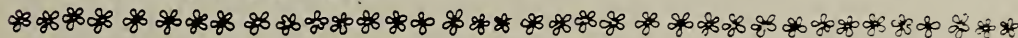
A physician may not accept a gift such as a radio, compact refrigerator, or the like from a manufacturer or a distributor of drugs, remedies, appliances or services for prescribing these products for his patients.

According to the AMA Judicial Council opinion adopted in November, 1967, this practice amounts to rebating. The Council further states that it is ethically improper because it could influence the physician to prescribe the donor's product. If a product or service is prescribed for its effectiveness, it would be preferable that it be discounted so that the patient, rather than the physician, benefits.

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 their families and friends

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 CARNIVAL**

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- Luxurious dinners nightly at restaurants of your choice from list of top restaurants to be supplied

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Return this reservation promptly to insure space. Reservations limited. AITS reserves the right wherever necessary to substitute comparable hotel accommodations (single rates \$100 additional).

Psychiatry In Illinois

(Continued from page 720)

cial assistance is necessary for maintaining this unique and valuable service.

Conclusion

It is clear that by 1940, to review our data, chains and strait jackets are no longer used for patients mentally ill. Theoretically, restraints are used only on doctor's orders and personnel are better trained to handle their patients.

As we recall the earlier history of psychiatry, the first of the modern trends of psychiatry arose in the 18th Century when such men as Phillipe Pinel pioneered to move the mentally ill from prison to an insane asylum, and in the 19th Century Dorothy Dix stirred editors, legislators and the public to improve these disgracefully neglected asylums.

Then early in the 20th Century came the introduction of somatic treatment used extensively in 1940-1950 period which is still effective. Therapeutic nihilism of the mentally ill ended with the introduction of malaria therapy by Wagner Youregg for general paresis and the understanding of the psyche psychologically with the introduction of the science of psychoanalysis by Freud. Bizarre and symbolic symptoms began to have *meaning*. The psychological

understanding of the total organism in his environment with its stresses and defenses is now incorporated in the comprehensive understanding of a patient and is no more dichotomized between the physical and psychological.

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ISMS Professional Liability Program

(Continued from page 736)

of coverage. But, mind you, the program is not emphasizing rates so much as market stability, good control, good legal climate and availability. A better legal climate will help stabilize the rates, because these will reflect the loss experience as it occurs in Illinois.

How are the rates structured?

They are based on two classes of counties, and five major categories of specialty. The physician will be assigned a rate on the basis of information submitted in his application form. In cases of doubt about an application, the insurer will consult ISMS. (See Sample Rate Table.)

What led to the selection of Employers' Group as underwriter, and Parker, Aleshire as administrator?

The arrangements with Employers' Group grew out of a five-month study by the Medical Economics Committee. We found that this company had gained valu-

able experience as underwriter of the Florida Medical Association's malpractice program, which parallels ours in its aims... that the association and company were mutually satisfied. Parker, Aleshire has demonstrated its excellent service as administrator of our Group Disability and Major Medical plans.

What is necessary to assure the program's success?

The program is soundly conceived and organized, but our members must support it. Employers' Group hopes to have at least 4,000 ISMS members enrolled within five years. Let me emphasize that market stability—a basic advantage of this program—demands mutual responsibility. On the one hand, we are offering availability regardless of age or specialty... a balanced premium-rate structure... legal safeguards. On the other hand, there must be membership participation.



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A boat is a special thing, not for everyone. Doers, achievers, those more alive than most, are the ones who embrace the mystique of boating most readily. Whether sail or power, a boat is a refuge, or a party place, an art to be mastered, language to be learned and used, a means of exciting travel, a catalyst for friendships, a thing of great beauty, a source of much pride and a grandstand seat for many of nature's most wondrous spectacles. And if needed, a boat can be prestige and an outlet for competitive drive.

More perceptive than most of us, doctors are particularly aware of the benefits of boating and have gone to sea in proportionately larger numbers than has any other profession. That's why we sell boats to so many doctors.

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Does The Psychiatric Hospital Serve Medicine?

Some treatment facilities seem to provide an unusual measure of aid and comfort to other disciplines, with the doctor's role apparently subsumed in a kind of miscellany of therapeutic activity.

This is not the case at North Shore Hospital. In policy and in practice, the doctor creates the program and treatment regime, drawing upon relevant aspects of the existing milieu to structure his patient's day.

While obviously beneficial and entirely necessary in patient management, the therapeutic environment must be astutely scaled to specific patient needs, as interpreted by the attending physician.

Patients referred to the hospital by the general practitioner and other medical specialists are cared for by the hospital's own psychiatric staff which, at the same time, provides continuity of care for all patients.

Hospital administration and medical responsibility are under one and the same person at this hospital: the superintendent and psychiatrist-in-chief. Consequently, patient welfare, and nothing else, defines hospital organization and the therapeutic programs.

The private psychiatric facility, as compared to other institutions and units of care, remains especially suited to the treatment of a wide range of mental disease entities. This is true in those instances where the patient is ambulatory, in need of relative freedom, and where an appropriate diversity of activity is indicated. Those conditions of daily living, in other words, which are required for the therapeutic rehearsal of recovery are uniquely available in such a hospital.

The remotivation programs for the medicare patients, the class rooms for the adolescents, the patient library, the outdoor and indoor games and parties, all of these professionally organized activities make up the hospital day—but again with sharp medical emphasis. Through weekly staffings, written orders, and discussions with staff the doctor remains entirely in command.

The hospital, in fulfilling its medical commitments, stands ready to offer consultation on office and home emergencies. In short, it is here (in a strikingly beautiful section of the North Shore) to serve doctors by keeping faith with the profession of medicine.

Telephone or write to Charles H. Jones, MD—Superintendent and Psychiatrist-in-Chief, North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois 60093—Telephone (312) 446-8440.

Acute Renal Failure

(Continued from page 704)

wise use of consultants and facilities experienced in the management of patients with acute renal failure.

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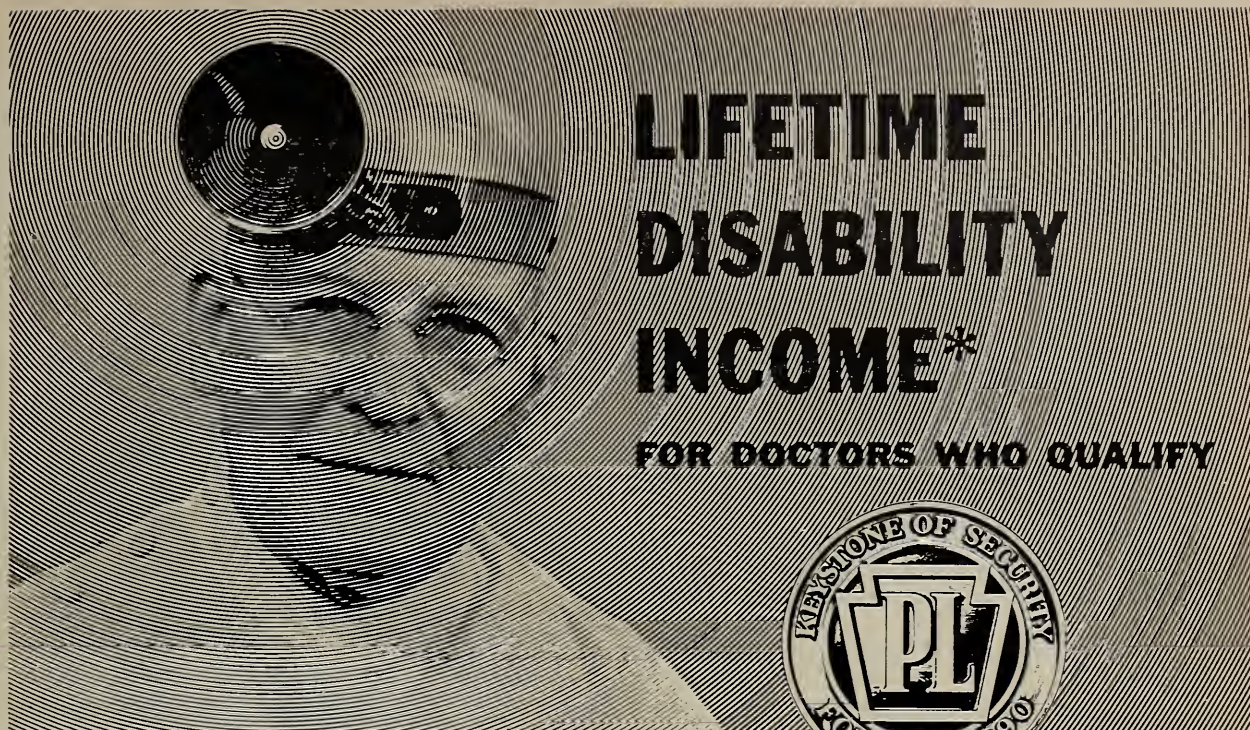
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Benefits for more than 94 million veterans and dependents of veterans are administered by the Veterans Administration. Included are more than 1,500 widows and children of Civil War veterans, two Indian Wars veterans and approximately 250 dependents, more than 10,000 Spanish-American War Veterans and 50,000 dependents, more than a million World War I veterans and almost 600,000 dependents, 1.7 million World War II veterans and a million dependents, almost 250,000 Korean Conflict veterans and 150,000 dependents.

Lipodystrophy

(Continued from page 734)

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As long as total disability, and regular medical attention continue from accident. Lump sum accidental death benefit. Lump sum payment in lieu of the monthly benefit if dismemberment or loss of sight results within ninety days from totally disabling accident.

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EFFECTIVE DATES OF COVERAGE. This policy covers accidents from noon of the policy date and sickness originating more than 30 days after the policy date, unless specifically excluded, except—it covers heart disease or hernia provided such conditions originate more than six months after the policy date.

EXCEPTIONS. Benefits are not payable for loss beginning while this policy is not in force; resulting from non commercial air travel, suicide or any attempt thereof, mental illness, loss beginning on or after the renewal date following your sixty-fifth birthday or retirement, whichever is first, except as otherwise provided; loss due to war or while in armed service; loss resulting from insured's intoxication or narcotics addiction, or extended world travel without company consent.

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After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
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and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.



Parepectolin[®]

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Temporo Mandibular Syndrome

(Continued from page 706)

Gum Chewing

A middle-aged woman came to my office because of vertigo. I checked her ears, teeth, and her bite. They were normal. Then I touched her temporomandibular joint and it was very tender. I asked her if she chewed gum. Her husband spoke up and said: "Does she! Only a 'carton' a day." I advised her to stop and report back in a week. She did and the tenderness and vertigo had cleared up.

Another individual complained of severe pain in the region of the left antrum with slight swelling. The area was tender to the touch. Trans-illumination showed a light shadow, but nothing was found when the antrum was irrigated.

The next morning he returned with facial paralysis (Bell's palsy) on the right side of the face. There was tenderness around the ears with subluxation and crepitus under the lower maxilla with a 12 millimeter overbite. His teeth were in excellent condition. I recommended a bite block immediately to correct the overbite.

In a few days there was less crepitus and the subluxation and pain subsided. He received electrical treatments over the temporomandibular joint, on the 7th nerve and the 5th on the opposite side. After two months of treatment, the paralysis improved considerably. I recommended that he continue wearing the bite block.

In conclusion, the temporomandibular syndrome may lead to a variety of symptoms that mimic many diseases.

IAP Membership

(Continued from page 748)

Martin Sopocy, R.Ph., Chairman of the IAP Membership Committee, and his Committee are currently involved in a campaign to retain existing and obtain new members.

The theme of the drive states one of the major objectives of IAP, "To provide the organizational machinery whereby the combined strength and counsel of all professions can be utilized for the advancement of professional ideals and the promotion of professional welfare."

The Illinois Society of Certified Public Accountants will meet at the Drake Hotel in Chicago June 26-28, 1968.

Black Ink Requested On Vital Statistics Forms

Since its inception on January 1, 1916, the State Office of Vital Statistics has accepted and filed in excess of 20 million birth, death, and fatal death records. It has statutory obligation to permanently preserve these records either in the original or in photographic or microphotographic form.

After 52 years of repeated handling for the purpose of issuing certified copies, and of housing in less than ideal temperature and humidity controlled quarters, thousands of these records have begun to seriously deteriorate. Therefore, it has become imperative for the State Office of Vital Statistics to record all these important documents in some photographic media.

In preparation for this process, numerous tests of photographic techniques have been made on both old and recent records. All test results show that *only black or*

dark blue inks photograph satisfactorily. Consequently the State Office of Vital Statistics now has established standards of acceptability for vital records which include a direction that all pen-and-ink entries be made with dark, unfading ink—preferably black. These instructions appear in the new handbooks for hospitals and funeral directors, and will appear in a forthcoming handbook for physicians.

Because the physician plays an important role in Illinois' vital statistics system by supplying, over his signature, medical data for birth certificates and by certifying, over his signature, causes of death and fetal death, the ISMS Liaison Committee to the State Office of Vital Statistics urges that all physicians cooperate in this request and make all pen-and-ink entries, including his signature, on these forms in either *black or dark blue unfading ink.*

OBITUARIES

***Dr. A. J. Dalton**, Champaign, died April 4 at the age of 84. He was a member of the staff and an electrocardiologist at Burnham City Hospital, a member of ISMS Fifty-Year Club.

***Dr. E. Harold Ennis**, 56, died Mar. 26. He was a past secretary of Sangamon County Medical Society, former member of the ACI board of directors and local chapter of the American Red Cross, American College of Surgeons, American College of Obstetricians and Gynecologists.

Dr. Joseph Foley, Waukegan, died May 3 at the age of 65. He was a physician on the staffs of St. Therese, Victory Memorial and Lake County General Hospital.

***Dr. William A. Gross**, 82, Chicago, died April 29.

***Dr. Harry D. Grossman**, a Chicago physician for 47 years died April 1 at the age of 69. He served on the staff of Michael Reese and Woodlawn Hospitals and was a major in the Army Medical Corps in World War II.

***Dr. Edwin N. Irons**, Chicago, 54, a specialist in internal medicine, died in Pres-

byterian-St. Luke's Hospital, where he had been a resident physician for 20 years and served as vice president of the hospital's medical staff.

***Dr. Harold L. Klawans**, Chicago, a staff member of Michael Reese Hospital, on the faculty of the University of Illinois Medical Center, died April 28 at the age of 65.

***Dr. Eugene J. O'Neill, Sr.**, Chicago, a physician on the south side for 50 years, died April 13 at the age of 82. He was a member of ISMS Fifty-Year Club.

***Dr. Nelson C. Phillips**, 90, Freeport's oldest practicing physician, died April 1. He was past president of the Stephenson County Medical Society, Freeport Board of Education, chief of staff of the Old Deaconess Hospital and a member of ISMS Fifty-Year Club.

***Dr. Paul E. Weimer**, Chicago, a physician and surgeon on the staff of South Shore Hospital, died April 26 at the age of 75. He was a member of ISMS Fifty-Year Club.

*Indicates member of Illinois State Medical Society.

**COOK COUNTY
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SPECIALTY REVIEW COURSE IN MEDICINE, Part 1, Sept.
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SPECIALTY REVIEW COURSE IN THORACIC SURGERY,
Sept. 16
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Re-
quest Dates
BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks,
July 8
FIBEROPTIC CULDOSCOPY & PELVIC PERITONEOSCOPY,
July 9
SURGICAL & RADIATION Rx OF GYN. MALIGNANCIES, Sept. 9
PROCTOSCOPY & VARICOSE VEINS, One Week, September 9
ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week,
Sept. 16
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Sept.
23
PULMONARY FUNCTION TESTS, Three Days, July 10
SURGERY OF THE HAND, One Week, September 16
RADIOISOTOPES, One or Two Weeks, First Monday Each
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CLINICAL ENDOCRINOLOGY, One Week, June 24
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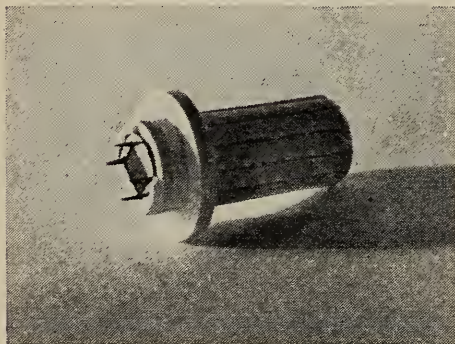
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THE VIEW BOX

(Continued from page 716)

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This case was treated by introducing a rectal tube during sigmoidoscopy. Of interest is the post reduction barium enema which shows "thumb printing" effect on the sigmoid loop, probably the result of hemorrhage and edema resulting from the condition.

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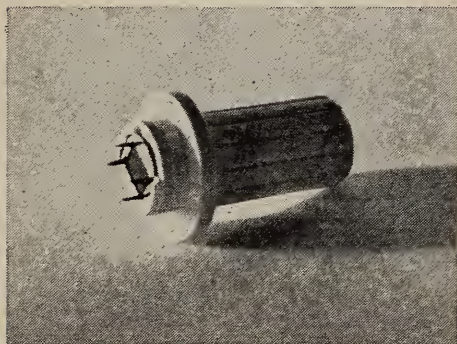


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(Continued from page 756)

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Composition: Simethicone 25 mg.
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Roentgenological Aspects Of IUCD's

(Continued from page 726)

However, Ayre¹ in his study of a group of nineteen patients found three with cervical dysplasia and six with endometrial metaplasia. He stresses the importance of cytological studies as a routine procedure. Further studies need to be done before definite conclusions can be reached.

Summary

1. The roentgenological method of location of IUCDs and the roentgenological diagnosis of complications of IUCDs are discussed.

2. The possible carcinogenicity of IUCDs has not been established.

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Revised Mental Health Code Mailed To ISMS Members

Substantial revision to the Illinois Mental Health Code will affect the practice of nearly every physician. In addition, new forms have been devised.

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U of I Medical Center Enrollment Up 7%

A total of 2,522 students—1,922 men and
600 women—have registered for the spring
quarter, 1968, at the University of Illinois
Medical Center Campus in Chicago.

According to Deane R. Doolen, assistant
director of Admissions and Records, the
total is a 7 percent gain, which amounts
to an additional 155 students as compared
to the same period last year.

Largest enrollment is in the College of
Medicine, reporting with 821 students
registered, followed by the College of Phar-
macy with 519, the College of Dentistry
with 374 (of which 26 are dental assisting
students), the Graduate College with 339
(of which 37 are duplicates registered in
other curriculums and 3 are registered with
the Chicago Circle Campus), and the Col-
lege of Nursing with 240.

Postgraduates number 269 (of which 257
are interns and residents in the Univer-
sity's Research and Educational Hospitals,
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